JOSH STEIN
Attorney General

State of North Carolina

Department of Justice
PO Box 629
Raleigh, NC 27602
Phone: 919-716-6820

STATEMENT OF CLAIMANT

This form is designed to assist you in making a claim against the State of North Carolina for damages or injuries which you believe to have been the result of negligence on the part of a State employee. Upon completion of this statement, please return it to the office from which it was received. Following an investigation by the Department of Justice you will be contacted and notified as to whether the State will voluntarily assume liability of your claim

---

1. Your Name: _____

2. Your Address: _____

3. City: _____ State: _____ Zip: _____

4.Telephone: Home:_____ Business: _____

4a Date of Accident:_____ County:_____

Under the laws of the State of North Carolina, before any liability can be placed upon the State, the person who has been damaged or injured must be able to name a specific State employee who was the direct cause of the accident. If a specific employee is not named the claim cannot be paid under any circumstances. Under the provisions of the laws of North Carolina, it is not sufficient that you can name a supervisor of foreman when the accident was caused by some other employee. It is also necessary that you describe exactly how you feel the State employee was negligent.

5. State agency involved: _____

6. State employee you consider negligent: _____

Address: _____

7. Explain in your own words how you were injured or damaged and in what way you believe the State employee named above was negligent: _____

_____

_____

_____

_____

8. Your Vehicle: Make: _____ Model: _____

Year: _____ License Number:_____ State: _____

Driver:_____ Age: _____

Owner of Vehicle: _____

Your Insurance Company and Policy Number: _____

Speed of Vehicle at the time of the accident: _____

Has the vehicle been repaired: Yes _____ No _____

IF the vehicle has been repaired, state where the vehicle was repaired: _____

Cost of repair: _____ Have the repairs been paid for: Yes _____ No _____

If the repairs were paid for, who paid for them: _____

If repairs have not been made, enclose two estimates.

9. State vehicle:

Agency:_____ Operator: _____

Address:_____ Make of Vehicle: _____

Model: _____ License No: _____ Year: _____

Speed of Vehicle:_____ If State vehicle was truck, state: Was it loaded: _____

With what: _____

How high was it loaded:_____ Was it covered: _____

10. If the State vehicle involved was a school bus, please complete the following section:

County: _____ Driver: _____

Address: _____ Age: _____ Sex: _____

Experience: _____

Bus Number: _____ License No: _____ Make: _____

Number of Students on the bus: _____ Estimated Speed: _____

11.Amount of damages: _____

The damages consist of the following: _____

_____

_____

_____

12. Injuries: NAME ADDRESS

_____

_____

_____

13. Nature of injuries: _____

_____

_____

14. Doctor(s): _____

Hospital(s) _____

Date of Treatment: _____

15. If there were any witnesses to the accident, please list their names below and their address:

NAMES ADDRESS

_____

_____

_____

16. Investigating Officer: _____

Department: _____

17. SHOW HOW ACCIDENT OCCURRED BY USING ONE OF THESE DIAGRAMS:

IMPORTANT: Please fill a diagram showing position of automobile and injured person (or other vehicle with which insured's automobile collided) with direction in which both were proceeding.

YOUR CAR OTHER CAR TRAILER

BUS MOTORCYCLE PEDESTRAIN

Date of report: _____, 20___ _____
(Signature of Person making report)