State of North Carolina
Department of Justice
P. O. Box 629
Raleigh
27602

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.

Your Name _____

2 Your Address _____

3 Telephone Business _____ Home _____

Date of Accident _____ Time: _____ Place _____

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 or 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 _____

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

_____

_____

_____

_____

_____

_____

If the claim you are presenting involves a motor vehicle accident, please complete the following section.

8 Your Vehicle:

Make: _____ Model: _____ Year: _____

License Number _____ State _____

Driver: _____ Age: _____

Owner of Vehicle: _____

Your Insurance Company and Policy No.: _____

Speed of vehicle at the time of the accident _____

Has the vehicle been repaired Yes _____ No

If the vehicle has been repaired, state Place where it 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: _____ Year: _____ License No.: _____

Speed of Vehicle _____ If State vehicle was a 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 _____

These damages consist of the following: _____

_____

_____

12. Injuries:

NAME	ADDRESS
_____	_____
_____	_____
_____	_____

13 Nature of injuries _____

_____

14. Doctor(s) _____

Hospital(s) _____

Dates of Treatment: _____

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

NAME	ADDRESS
_____	_____
_____	_____
_____	_____

16. Investigating Officer: _____ _____ _____

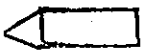
Department: _____

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

IMPORTANT: Please fill in 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

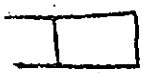


TRAILER

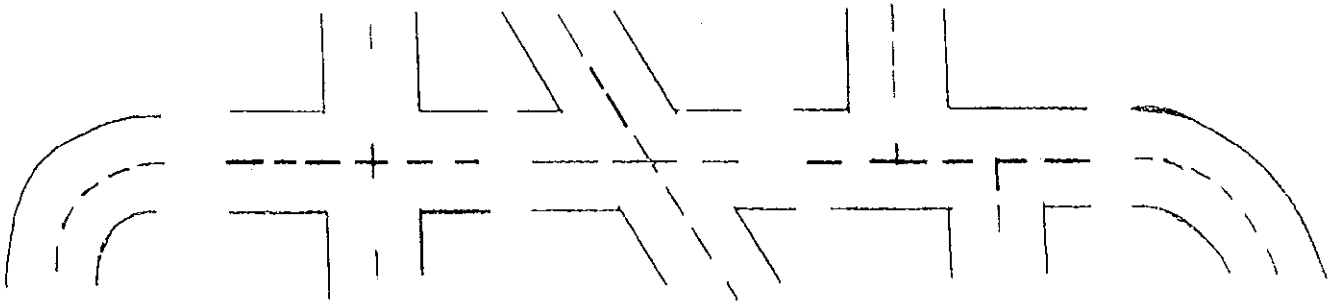
BUS

MOTORCYCLE

TEAMS



PEDESTRIAN



Date of report _____, 19____

_____

Signature of Person making report