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:

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
</tr>
</thead>
</table>

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.

Date of report ________________________, 19____

Signature of Person making report