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: ___________________


4a Date of Accident: _____________ County: ____________________ Social Security #: ________

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: ________________________________

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:
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
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 Number: ______________________
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: ______________________  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 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)