CITY OF KAUKAUNA LIABILITY CLAIM FORM

TIME & PLACE

DATE OF ACCIDENT_____TIME OF ACCIDENT_____ A.M. P.M.

LOCATION OF ACCIDENT, STREET_____CITY_____

STATE_____ ZIP CODE_____

DESCRIPTION OF ACCIDENT

FULL DESCRIPTION & CAUSE OF ACCIDENT_____

_____

_____

_____

_____

WITNESSES

NAME _____ NAME _____

ADDRESS_____ ADDRESS _____

_____ _____

INJURED PERSON & INJURIES

NAME OF PERSON INJURED_____AGE_____MARRIED_____SINGLE_____

STREET_____CITY_____S

TATE_____ZIP CODE_____PHONE NUMBER_____

NATURE & EXTENT OF INJURIES_____

_____

NAME OF DOCTOR OR HOSPITAL_____

STREET_____CITY_____

STATE_____ZIP CODE_____

BY WHOM IS THE INJURED PERSON EMPLOYED_____

DID THE INJURED LOSE TIME FROM WORK AS A RESULT OF THIS INJURY? YES_____NO_____

HAS THE INJURED PERSON RETURNED TO WORK? YES_____NO_____

DAMAGE TO PROPERTY

NAME OF OWNER_____

STREET_____CITY_____

STATE_____ZIP CODE_____PHONE_____

DESCRIPTION OF DAMAGED PROPERTY_____

_____

ESTIMATED COST OF REPAIRS_____

WHERE MAY THE PROPERTY BE SEEN?_____

DATE_____CLAIMANT SIGNATURE_____