CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

LACK KAREN L — 1/28/64
Last Name, First, Middle — Date of Birth

[redacted]
Street Address/Mailing Address

[redacted] — [redacted]
City, State Zip Code — Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name

Mailing Address

City, State Zip Code

Relationship to claimant: Attorney at Law ( ) or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A. 2/22/11 — 11:30 am
Date — Time

B. Describe the location or place of the accident or occurrence

Westfield — Central Ave Eastbound
Municipality — Exact location of the occurrence

between North & South Aves.

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

I was driving in the far right lane on Central Ave and was unable to avoid a huge pothole as there was a car behind me and to my left.

4. A. Claim for Damages (Check the appropriate block)

( ) Personal Injury (✓) Property Damage
( ) Other - Explain in detail_____

_____

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

_____

_____

B2. Do you claim permanent disability resulting from this injury?

( ) Yes ( ) No

If yes, describe the injuries believed to be permanent.

_____

_____

_____

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility

b. Address

c. Dates of treatment or services

d. Amount of charges to date

e. Amount paid or payable by other sources such as insurance

B4. If you claim loss of wages or income as a result of the injury, state

Name of Employer Address of Employer

Your Occupation Date of Employment

Rate of Pay Dates of absence from work

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

6. If you claim property damage:

A. Describe the property damage:

Side wall of tire on front passenger side ripped open due to pot hole.

B. The present location and time when the property may be inspected:.

Westfield

LOCATION DATE TIME

C. Date property was acquired.

D. Cost of property.

E. Value of property at time of accident.

F. Description of damage.

Rip to side wall of tire

G. Has the damage been repaired? Yes

If yes, by whom, when and cost of repair.

STS		
Repaired by	When	Costs of Repairs

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

I had to immediately replace the damaged tire.

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

B. The amount of the claim.

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

Union County

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

Road should have been repaired by Union County.

10. State the name and address of any other persons against whom **you** are making a claim arising out of this accident and your theory of negligence or wrongful acts by **them**.

_____

_____

_____

11. State the names and address of all witnesses to the accident or occurrence.

Christopher Tavamaschi
Name of Witness

[redacted]
Address

_____
Name of Witness

_____
Address

12. A. State the names of all police officers and police departments **who** investigated the accident and attach a copy of the police report, if any.

_____
Name of Police Officer

_____
Police Department

_____
Name of Police Officer

_____
Police Department

B. Copy of Police Report attached:
( ) Yes ( ) No

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice. No

_____

_____

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

_____

_____

14. Are any of the losses or expenses claimed herein covered by **any** policy of insurance.
No

_____

_____

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

( ) Yes ( ) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

A. Copies of itemized bills for each medical expense and other losses and expenses claimed.

B. Full copies of all appraisals and estimates of property damage claims by you.

C. Copies of all written reports of all expert witnesses and treating physicians.

D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.

E. Completed "Authorization for Release of Health Information", see attached form.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED: 3/6/11

Claimant or person filing claim on behalf of claimant.

STS TIRE & AUTO CENTERS

It's a trust thing.

Experience the Difference . . .
EMPLOYEE OWNERSHIP
at STS

Visit our Website at www.ststire.com

STS Westfield WF8-012
343 South Avenue East
Westfield, NJ 07090-1465
Tel: (908)232-1300

ACCOUNT NO.		INVOICE DATE	INVOICE
12	Cash	02/22/11	311064

PAGE: 1

VEH: 2010 M/B C300 MIL: 003,042
LIC: ZVR85H

SOLD TO

LACK
[redacted] home add
[redacted] home ph #

CONTROL NO.	ORDER DATE	CUST. ORDER NO.	SLS	TERMS	DATE SHIPPED	SHIP VIA	SLS ORD
283564	02/22/11		001	VMDD	02/22/11	SHOP INSTALLED	

ITEM NO.	DESCRIPTION	ORDERED		SHIPPED	QAP RFPSI	PRICE	SVC. BY	EXTENSION
NJTT	NEW JERSEY TIRE TAX	1	0	1		1.50		1.50
61018	SHOP SUPPLIES	1	0	1		1.14		1.14
32312	225/45HR17 MI PI MXM4 MO	1	0	1		199.87		199.87
TSP	PERFORMANCE TIRE PACKAGE	1	0	1		18.95		18.95
PBALB	PERFORMANCE COMPUTER BALANCE	1	0	1		0.00		0.00
	*ACCU-TORQ TIGHTENING OF LUGNUTS							
	*CLEAR-COAT WHEEL WEIGHTS							
610008	SNAP-IN VALVE STEM	1	0	1		0.00		0.00
6056.7A	TIRE DISPOSAL	1	0	1		0.00		0.00
	*30 DAY TEST DRIVE (ASK FOR DETAILS)							
	*FREE INFLATION CHECK AND							
	*TIRE ROTATION FOR LIFE OF THE TIRE							

TAXABLE: 219.96 NON-TAX: 1.50 Sub-total : 221.46
Tax 7.000%: 15.40

INVOICE TOTAL 236.86

reby waive my rights to a written estimate for the requested repairs, and orize the above repair work to be done along with necessary materials. and your employees may operate above vehicle for purposes of testing, ection or delivery at my risk. It is understood that this company assumes esponsibility for loss or damage by theft or fire to vehicle or articles left ehicle placed with them for storage, sale, repair or while road testing. xpress mechanic's lien is acknowledged on above vehicle to secure the amount of repairs eto. I agree that the title to the merchandise described above remains with the seller until such as all obligations noted herein are met and paid in full. It is understood that all parts not nwise described are new.

CUSTOMER

CUSTOMER SIGNATURE

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN, SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

Morris Michael S
Last Name, First, Middle

11/09/1987
Date of Birth

[redacted]
Street Address/Mailing Address

[redacted]
City, State Zip Code

[redacted]
Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name

Mailing Address

City, State Zip Code

Relationship to claimant: Attorney at Law ( ) or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A.

Date 1/24/11 Time 10:00am

B. Describe the location or place of the accident or occurrence

Plainfield
Municipality

Welfare Lobby
Exact location of the occurrence

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

When Returned my belt the main piece of the belt was missing.

4. A. Claim for Damages (Check the appropriate block)

( ) Personal Injury (✓) Property Damage
( ) Other - Explain in detail Missing an expensive piece to my belt.

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

B2. Do you claim permanent disability resulting from this injury?

( ) Yes (✓) No

If yes, describe the injuries believed to be permanent.

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility

b. Address

c. Dates of treatment or services

d. Amount of charges to date

e. Amount paid or payable by other sources such as insurance

B4. If you claim loss of wages or income as a result of the injury, state

Name of Employer Address of Employer

Your Occupation Date of Employment

Rate of Pay Dates of absence from work

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

6. If you claim property damage:

A. Describe the property damage:
The barrel of my gun belt is missing.

B. The present location and time when the property may be inspected:.

Plainfield Social Services 2-10-11
LOCATION DATE TIME 10am

C. Date property was acquired.

2008

D. Cost of property.

E. Value of property at time of accident.

I paid $350 for my belt.

F. Description of damage.

Barrel to my butt is MISSing

G. Has the damage been repaired? ~~no~~ In the Shop

If yes, by whom, when and cost of repair.

Repaired by	When	Costs of Repairs

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

B. The amount of the claim.

$100

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

Union

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

on duty officers Sheriff officers

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

when I gave my butt to the officer it was in perfect condition. Then when I picked the butt up my barrel was missing. So in between the time something happened to where as though the barrel came up missing.

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

11. State the names and address of all witnesses to the accident or occurrence.

Name of Witness — Address

Name of Witness — Address

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

Name of Police Officer — Police Department

Name of Police Officer — Police Department

B. Copy of Police Report attached:
( ) Yes ( ) No

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice.

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

NO

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

( ) Yes (✓) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

A. Copies of itemized bills for each medical expense and other losses and expenses claimed.

B. Full copies of all appraisals and estimates of property damage claims by you.

C. Copies of all written reports of all expert witnesses and treating physicians.

D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.

E. Completed "Authorization for Release of Health Information", see attached form.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED: 1-31-11

Michael Morris

Claimant or person filing claim on behalf of claimant.

25

Monday
September
2006

7:00 Michael Morris
7:30 [redacted] Home ph #
8:00
8:30 [redacted] home add
9:00
9:30 I came in gave my
10:00 belt to the
10:30 officer then when
11:00 I came back to
11:30 get my belt
12:00 it was a piece
12:30 missing The belt
1:00 cost me $35
1:30 And I would
2:00 like to be reinterviewed
2:30 for my belt.
3:00
3:30
4:00
4:30
5:00 10.00

UNION COUNTY SHERIFF

INVESTIGATION REPORT

CC No.

1 Referral/Connecting/Property Slip #	2 Code	3 UCR Code	4 Trans Disc No.	5 Case Number
				R-11-256

6 Crime ☐ Incident ☒	7 Patrol District	8 NJS	9 Victim's Name
		Damage to Property	Michael Morris

10 Race	11 Sex	12 Age
African American	M	23

13 Time & Date Crime or Incident Occurred	14 Hour	15 Week	16 Month	17 Day	18 Year
Date Between	8:30		1	24	11
AND Time At	10:35		1	24	11

19 Home Address- City - State — Phone: [redacted]

Cell / Pager No.: [redacted]

20 Location	21 Employer - School	22 Business Phone
Lobby 200 W. 2nd St. Plfd		

23 Time & Date Unit Notified	24 Person Reporting Crime	25 Age	26 Time & Date Reported
10:35am on 1/24/11			10:35 on 1/24/11

27 Type of Premises	28 Code	29 Weapons - Tools	30 Code	31 Address	32 Phone
office bldg					

33 Vehicle	34 Year	35 Make	36 Body Type	37 Color	38 Reg. Number & State	39 Serial Number

Value Stolen Prop.	40 Currency	41 Jewelry	42 Furs	43 Clothing	44 Auto	45 Misc.
				belt		

46 Total Value Stolen	47 Total Value Recovered	48 Teletype ☐ Yes ☐ No	49 Alarm No.	50 Weather	51 Status Crime	52 Status Case
damaged $350.						

53 CLEARED BY ARREST ADULT ☐ JUVENILE ☐ ADULT & JUVENILE ☐ NARCOTICS INVOLVED ☐

LIST OF INVOLVED - LIST AND IDENTIFY ADDITIONAL VICTIMS - DESCRIBE PERPETRATORS OR SUSPECTS - ACTION TAKEN INCLUDE FINDINGS AND OBSERVATIONS OF INVESTIGATOR - PHYSICAL EVIDENCE FOUND - WHERE - BY WHOM - DISPOSITION AND TECHNICAL SERVICES PERFORMED - INTERVIEW OF VICTIMS - WITNESSES - PERSONS CONTACTED - SUSPECTS- LIST - DESCRIBE STOLEN PROPERTY - VALUE - COURT ACTION - ATTACH STATEMENTS

54 PERSON INVOLVED	ADDRESS	PHONE NO.	RACE	SEX	DOB	ARREST SUSPECT WITNESS
Sgt. Trevor Clarke	200 West 2nd St. Lobby	908-791-2053				W
S/O Nakera Sherman-Belin	200 West 2nd St. Lobby	908-791-2053				W
Capt. Gail Alexander	200 West 2nd St. Lobby	908-791-2053				W

Narrative

After Mr. Morris retrieved his belt from lobby security, he claimed the officer was responsible for a missing cylinder piece on the belt. The belt is held at security because the buckle is shaped like a handgun. Mr. Morris frequents this building to receive services and knows the procedure of leaving this belt at security. I had him write his general information and description of the incident. He writes," I came in gave my belt to the officer than when I came back to get my belt it was a piece missing. The belt cost me $350 and I would like to be reimbursed for my belt."

I received the tort pact via fax the next day on the 25th of January. I was able to review the security cameras in between the time of the incident and Mr. Morris return on the 31st. The security camera revealed Mr. Morris wearing a striped hooded top, dark coat and jeans removing something from his blue bookbag while on line.

55 Type Name	56 Badge Number	57	58 Date of Report
Capt. Gail Alexander	**	Page 1 of 2 Pages	2/1/11 Time 1330hrs
Signature: [signature]	59 Typist: gsa	60 Desk Supervisor:	

Closer inspection of the footage while he is moving through the line shows a rolled up belt in his right hand.

As Mr. Morris reaches the security table he placed the rolled up belt into the security container along with his blue bookbag and proceeds through the magnetometer.

Sgt. Clarke removes the rolled up belt from the container and places it into an envelope.
Mr. Morris retrieves the belt still rolled up from S/O Sherman-Belin about 10:35am.

On the 31st Mr. Morris returned, I provided Mr. Morris with the tort paperwork in the security lobby. I asked Mr. Morris if he was sure that we damaged his belt. He said that he knows it was perfectly fine beforehand because of the weight of the belt. I asked him where did he removed the belt. He said that it was by the entrance doors and pointed to an area that is in close proximity to the security table.

After Mr. Morris finished the paperwork, I reviewed the paperwork with Mr. Morris to ensure he answered as many of the questions as possible. I provided him with a copy.

The building manager copied the security footage to VHS.

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

Mortellito, Janine Marie — January 1, 1970
Last Name, First, Middle — Date of Birth

[redacted]
Street Address/Mailing Address

[redacted]
City, State Zip Code

[redacted]
Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name

Mailing Address

City, State Zip Code

Relationship to claimant: Attorney at Law ( ) or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A. Date 1/31/11 & 2/4/11 Time mid-afternoon Daytime

B. Describe the location or place of the accident or occurrence

Union County Rd → Michigan Avenue
Municipality — Exact location of the occurrence

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

There was a huge pothole in the street that you could not avoid due to parked cars & 1 lane only on street. (See pics of repaired pothole NOW

4. A. Claim for Damages (Check the appropriate block)

( ) Personal Injury (✓) Property Damage
( ) Other - Explain in detail 2 tires & rims on my car both Damaged beyond repair & needing to be replaced.

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

N/A

B2. Do you claim permanent disability resulting from this injury?

( ) Yes (✓) No

If yes, describe the injuries believed to be permanent.

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility N/A

b. Address N/A

c. Dates of treatment or services N/A

d. Amount of charges to date N/A

e. Amount paid or payable by other sources such as insurance N/A

B4. If you claim loss of wages or income as a result of the injury, state

N/A
Name of Employer Address of Employer

N/A
Your Occupation Date of Employment

N/A
Rate of Pay Dates of absence from work

Date returned to work N/A

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

6. If you claim property damage:

A. Describe the property damage: 2 tires & 2 rims on my 2008 Pontiac G6 convertible

B. The present location and time when the property may be inspected:. Currently at the shop. when done it will be back at my home

ADDRESS [redacted]

LOCATION [redacted] DATE 3/3/11 TIME 2pm

C. Date property was acquired.

DEC 30, 2010

D. Cost of property. $

E. Value of property at time of accident.

F. Description of damage.

2 tires & 2 rims replaced

G. Has the damage been repaired? Yes

If yes, by whom, when and cost of repair.

Village Auto — Repaired by
2/23-11 — When
$ — Costs of Repairs

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

N/A

B. The amount of the claim.

N/A

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

Union County Roadway - Michigan Avenue, Kenilworth, NJ 07033

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

Union County Public Works! The potholes all up & down Michigan Avenue are HORRIBLE & all are still not fixed!!

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages. Their Lack of Urgency To repair & fix the County ROADS quickly not wait until it causes tremendous damage!

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
N/A		
N/A		

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

( ) Yes (✓) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

A. Copies of itemized bills for each medical expense and other losses and expenses claimed.

B. Full copies of all appraisals and estimates of property damage claims by you.

C. Copies of all written reports of all expert witnesses and treating physicians. N/A

D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income. N/A

E. Completed "Authorization for Release of Health Information", see attached form. N/A

Village Automotive Services

1225 Magie Ave
Union NJ 007083
908-289-1423

3/4/2011 3:42 PM

Repair Order #16441

Mortellito, Janine
[redacted]

Day Phone * [redacted] home ph.
Eve Phone * [redacted] cell ph.

Vehicle : 2008 Pontiac G6 3.5 L 214 CID V6 OHV with VVT
VIN : [redacted]

Tag/State : WGA73T / NJ
Color : Blue
Last Mileage : 20900
Odometer In : 35035
Odometer Out : 35035

Created : 3/1/2011 2:17:36 PM

Qty	Code/Tech*	Reference	Description	Condition	Unit Price	Price
1	006*	TOWING	tow charges		$65.00	$65.00
	tow car from michigan ave kenilworth both right side rims bent					
2	-	RIM	wheel tire rim 18x7 pontiac refurbished		$300.00	$600.00
2	-	TIRE	goodyear eagle 225 50 r 18		$150.00	$300.00
2	006*	MOUNT	Mount Balance		$20.00	$40.00

Labor		$105.00
Parts		$900.00
Sublet/Misc.		$0.00
Other Charges		$5.00
Charges		$0.00
Sales Tax	Tax @ $1,010.00 * 7.0000%	$70.70
	Repair Total	$1,080.70

Tech	Certification #
006	

I hereby authorize the repair work herein set forth to be done along with the necessary material and agree that you are not responsible for loss or damage to vehicle or articles left in vehicle in case of fire, theft or any other cause beyond your control. I hereby grant you and/or your employees permission to operate the vehicle herein described on streets, highways or elsewhere for the purpose of testing and/or inspection. An express garagekeeper's lien is hereby acknowledged on the above vehicle to secure the amount or repairs thereto. All Vehicles left over 48 hrs. after repairs are completed WILL INCURE A $25.00 PER DAY STORAGE FEE. .

☐ Customer Signature _____

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED:

Claimant or person filing claim on behalf of claimant.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: _____

Soc. Sec. Number: _____ **Date of Birth:** _____

Patient Address: _____

City / State / Zip Code: _____

My health information is to be released by the following physicians, hospitals, healthcare facilities and/or healthcare providers:

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Not applicable for Plaintiff

The health information to be released (include specific description of injury and dates of treatment):

_____

_____

_____

My health information is to be released to:

The County of Union
Office of County Counsel
10 Elizabethtown Plaza
Elizabeth, New Jersey 07207

The purpose of this disclosure is to allow the County of Union to evaluate the medical condition of the individual listed above in connection with their Tort Claim against the County. This information will be utilized by the County of Union to determine the validity and severity of any claimed medical condition for the purpose of potential settlement. The County reserves the right to have the disclosed health information evaluated by an outside physician or healthcare provider, as appropriate.

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. I understand that authorizing disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that I may obtain a copy of the information to be used or disclosed. The County of Union may not condition treatment, payment, enrollment or eligibility for health benefits on whether or not this Release is executed. I understand that I may revoke this authorization at any time by notifying the County of Union, Office of County Counsel in writing; however, this revocation will not have any effect on actions taken prior to any revocation. If this authorization is not revoked, it will terminate one year from the date of my signature. This Release is intended to comply with the Privacy Regulations enacted under the *Health Insurance Portability and Accountability Act* (HIPAA). (45 C.F.R. 164.508).

Printed Name of Patient Authorizing this Release: N/A
(Person making claim)

Date: N/A **Signature:** N/A

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN, SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

UNION COUNTY COUNSEL
RECEIVED
MAR - 8 2011
ADMINISTRATION BUILDING
ELIZABETH, NJ

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

NOGUEIRA, ROBERT O
Last Name, First, Middle

05-27-1971
Date of Birth

[redacted]
Street Address/Mailing Address

[redacted]
City, State Zip Code

- Not needed as per call to office
Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name

Mailing Address

City, State Zip Code

Relationship to claimant: Attorney at Law ( ) or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A. 2-8-11
Date 2/8/2011 Time 11:00am

B. Describe the location or place of the accident or occurrence

Garwood NJ
Municipality

Kings PARKING LOT ENTRANCE
Exact location of the occurrence
CLOSEST TO HOME DEPOT
SOUTH AVENUE, ~~CRANFORD~~
GARWOOD, NJ

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

While enterring Kings Supermarket Parking lot at driveway a large pot-hole was filled with water from melted snow and was not seen at street side of driveway. Flat noticed by the time I reached parking spot in supermarket lot

4. A. Claim for Damages (Check the appropriate block)

( ) Personal Injury (✓) Property Damage
( ) Other - Explain in detail Irreparable side-wall damage to passenger side front tire

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

N/A

B2. Do you claim permanent disability resulting from this injury?

( ) Yes (✓) No

If yes, describe the injuries believed to be permanent.

N/A

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility

N/A

b. Address

N/A

c. Dates of treatment or services

N/A

d. Amount of charges to date

N/A

e. Amount paid or payable by other sources such as insurance

N/A

B4. If you claim loss of wages or income as a result of the injury, state

N/A
Name of Employer — Address of Employer

N/A
Your Occupation — Date of Employment

N/A
Rate of Pay — Dates of absence from work

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

N/A

5. Set forth any and all other losses or damages claimed by you.

Tire & cost of repair

6. If you claim property damage:

A. Describe the property damage: The pot-hole caused side wall damage to my tire that caused for the tire to ~~be~~ need replacement.

B. The present location and time when the property may be inspected:.

N/A — LOCATION
N/A — DATE
N/A — TIME

C. Date property was acquired.

12-25-09

D. Cost of property.

$99.93

E. Value of property at time of accident.

Unknown N/A.

F. Description of damage.

Irrepairable side wall damage to tire and rim bent

G. Has the damage been repaired? Yes

If yes, by whom, when and cost of repair.

STS Tire and auto	2-8-11	$22.60 flat tire swit
Repaired by	When	Costs of Repairs to spare -
BJs tire Center	2-9-11	Replacement of tire
		$45.64

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

22.60 (STS) + 45.64 (BJs) = 68.24

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

Receipts for above

B. The amount of the claim.

$68.24

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

County of Union
Township of Garwood, County Road

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

N/A

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

failure to repair pot-hole on County Road
2 other people had damage on same pot hole

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

None

11. State the names and address of all witnesses to the accident or occurrence.

N/A — Name of Witness — Address

N/A — Name of Witness — Address

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

None required — Name of Police Officer — None required — Police Department

— Name of Police Officer — Police Department

B. Copy of Police Report attached:
( ) Yes (✓) No N/A

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice.

No

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

N/A

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

No-

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
N/A	—	—
N/A	—	—

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

( ) Yes (✓) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

A. Copies of itemized bills for each medical expense and other losses and expenses claimed.

B. Full copies of all appraisals and estimates of property damage claims by you.

C. Copies of all written reports of all expert witnesses and treating physicians.

D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.

E. Completed "Authorization for Release of Health Information", see attached form.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED: 2-25-11

Claimant or person filing claim on behalf of claimant.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: _____ Not Applicable.

Soc. Sec. Number: _____ **Date of Birth:** _____

Patient Address: _____

City / State / Zip Code: _____

My health information is to be released by the following physicians, hospitals, healthcare facilities and/or healthcare providers:

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

The health information to be released (include specific description of injury and dates of treatment):

_____

_____

_____

My health information is to be released to:

The County of Union
Office of County Counsel
10 Elizabethtown Plaza
Elizabeth, New Jersey 07207

The purpose of this disclosure is to allow the County of Union to evaluate the medical condition of the individual listed above in connection with their Tort Claim against the County. This information will be utilized by the County of Union to determine the validity and severity of any claimed medical condition for the purpose of potential settlement. The County reserves the right to have the disclosed health information evaluated by an outside physician or healthcare provider, as appropriate.

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. I understand that authorizing disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that I may obtain a copy of the information to be used or disclosed. The County of Union may not condition treatment, payment, enrollment or eligibility for health benefits on whether or not this Release is executed. I understand that I may revoke this authorization at any time by notifying the County of Union, Office of County Counsel in writing; however, this revocation will not have any effect on actions taken prior to any revocation. If this authorization is not revoked, it will terminate one year from the date of my signature. This Release is intended to comply with the Privacy Regulations enacted under the *Health Insurance Portability and Accountability Act* (HIPAA). (45 C.F.R. 164.508).

Printed Name of Patient Authorizing this Release: Not applicable
(Person making claim)

Date: _____ **Signature:** _____

993003 REV. 6/10

DATE: _____

MEMBER NAME: [redacted]	MEMBER # [redacted]	TIME IN
STREET ADDRESS: [redacted]	MAKE MODEL	
CITY / STATE / ZIP CODE: [redacted]	YR. PLATE #	TIME OUT
MEMBER TELEPHONE [redacted]	ODOMETER	

MEMBER COMPLETELY FILLS IN ABOVE AND SIGNS BELOW

D.O.T. #'s

1. 2.

3. 4.

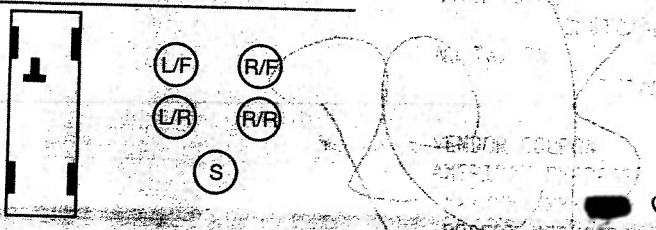
ROAD HAZARD FREE WITH EVERY TIRE PURCHASE	TIRES PURCHASED	/	BRAND:
TIRE SERVICE INSTALLATION **$15.00** PER TIRE *INCLUDES*			SIZE:
LIFETIME TIRE BALANCE			
LIFETIME FLAT REPAIR (R.M.A. STANDARDS)			
LIFETIME TIRE ROTATION			
MOUNTING AND NEW RUBBER VALVE STEM			
RESET TPMS (IF NECESSARY)			
TIRE DISPOSAL			

REGISTER VALIDATION:

TIRE BAY SERVICES	QTY.	STYLE #	UNIT PRICE	TOTAL
HIGH SPEED BALANCE		080365		
TIRE ROTATION		556572		
MOUNT / DISMOUNT		804940		
TIRE REPAIR		586331		
WHEEL LUG NUT		804959		
TIRE DISPOSAL		523070		

PRE-VEHICLE CONDITION / DESCRIPTION:

	MISSING	DAMAGED	OK
RIMS			
H-CAPS			
C-CAPS			
LUG NUTS			
	ON	OFF	
TPMS TELLTALE			



[redacted] credit card # redacted per OPRA.

NOTES/SPECIAL INSTRUCTIONS:	USE THIS SECTION TO NOTE ANY ADDITIONAL ISSUES BEFORE OR AFTER INSTALLATION
TORQUE FT. LB.	
AIR PRESSURE	

080365

YOUR INSTALLER IS _____ BAY NO _____

Original Tread Depth Chart

	14/32	13/32	12/32	11/32	10/32	9/32	8/32	7/32
	PERCENTAGE OF USABLE TREAD REMAINING							
14/32	100							
13/32	92	100						
12/32	83	91	100					
11/32	75	82	90	100				
10/32	67	73	83	89	100			
9/32	58	64	70	78	88	100		
8/32	50	55	60	67	75	86	100	

TIRE MANAGER ON DUTY QUALITY CHECK

- LUG NUTS TIGHTENED TO MANUFACTURER'S SPECIFICATIONS ☐
- SECURED HUB CAPS ☐
- PROPER TIRE INFLATION ☐
- VALIDATED PICK UP SLIPS & RECEIPTS TO MATCH INVOICE ☐

REVIEWER X _____

TIME CHECKED OUT: _____ AM PM

ATTENTION: FOUR (4) WHEEL DRIVE/AWD VEHICLES

I have been advised by a BJ's Team **Member** that it is suggested by manufacturers of four (4) Wheel Drive **(4x4)** and All Wheel Drive (AWD) vehicles that all four (4) tires be replaced at the same time. Not doing so may lead to severe damage to the front **and** rear differentials.

Club Member please initial ONE of the two options below that is applicable to this tire purchase.

1. I understand the potential for damage **and** accept any and all liability for not choosing to replace **all four** (4) tires at the same time.
_____ (Club Member **Initials**)

2. I understand the potential for damage but the vehicle involved in this tire purchase is not an All Wheel Drive **or** four (4) Wheel Drive vehicle **–OR-** I AM CHOOSING to replace **all four** (4) tires on this tire purchase.
_____ (Club Member **Initials**)

ATTENTION: PURCHASES OF LESS THAN FOUR (4) TIRES

I have been advised by a BJ's Team **Member** that tire manufacturers suggest that on new tire purchases **consisting** of less than all four(4) tires

MEMBER NAME:	MEMBER #
STREET ADDRESS: [redacted]	MAKE
CITY / STATE / ZIP CODE: [redacted]	YR. PI #
MEMBER TELEPHONE [redacted]	ODOMETER

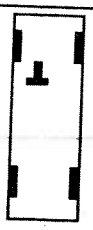
MEMBER COMPLETELY FILLS IN ABOVE AN

D.O.T. #'s
1. 2.
3. 4.

ROAD HAZARD FREE WITH EVERY TIRE PURCHASE				TIRES PU
TIRE SERVICE INSTALLATION **$15.00** PER TIRE *INCLUDES*				
LIFETIME TIRE BALANCE				
LIFETIME FLAT REPAIR (R.M.A. STANDARDS)				
LIFETIME TIRE ROTATION				
MOUNTING AND NEW RUBBER VALVE STEM				
RESET TPMS (IF NECESSARY)				
TIRE DISPOSAL				
TIRE BAY SERVICES	QTY.	STYLE #	UNIT PRICE	TOTAL
HIGH SPEED BALANCE		080365		
TIRE ROTATION		556572		
MOUNT / DISMOUNT		804940		
TIRE REPAIR		586331		
WHEEL LUG NUT		804959		
TIRE DISPOSAL		523070		

PRE-VEHICLE CONDITION / DESCRIPTION:

	MISSING	DAMAGED	OK
RIMS			
H-CAPS			
C-CAPS			
LUG NUTS			
	ON		OFF
TPMS TELLTALE			



L/F R/F L/R R/R S

NOTES/SPECIAL INSTRUCTIONS:	USE THIS SECTION TO NOTE ANY ADDITIONAL ISSUES BEFORE OR AFTER INSTALLATION
TORQUE FT. LB.	
AIR PRESSURE	

YOUR INSTALLER IS_____ BAY NO_____

Original Tread Depth Chart

	14/32	13/32	12/32	11/32	10/32	9/32	8/32	7/32
	PERCENTAGE OF USABLE TREAD REMAINING							
14/32	100							
13/32	92	100						
12/32	83	91	100					
11/32	75	82	90	100				
10/32	67	73	83	89	100			
9/32	58	64	70	78	88	100		
8/32	50	55	60	67	75	86	100	
7/32	42	45	50	56	63	71	83	100

TIRE MANAGER ON DUTY QUALITY CHECK

LUG NUTS TIGHTENED TO MANUFACTURER'S SPECIFICATIONS ☐
SECURED HUB CAPS ☐
PROPER TIRE INFLATION ☐
VALIDATED PICK UP SLIPS & RECEIPTS TO MATCH INVOICE ☐
REVIEWER X _____
TIME CHECKED OUT: _____ AM PM

1000 ROUTE ONE NORTH
EDISON, NJ
732-632-1800

U N E V E N E X C H A N G E

0026 061 2031 02/09/11
CASH-1 155 1 17:57:42

****
*** MEMBERSHIP ID. 06743076082 **
*** MEMBERSHIP EXPIRES ON 01/12 **
****

CASH OR CREDIT
LUMEI NOGUEIRA [redacted] home address
[redacted]

625144	UNR205/65R15	76.99 R
	ENVIRON.TAX	1.50N-R
	SERVICE PKG	15.00 -R
642365	UNR205/65R15	82.99
	ENVIRON.TAX	1.50N
	SERVICE PKG	15.00
	SUBTOTAL	6.00
NJ Tax 7%		.42
	TOTAL	6.42
AMERICAN EXPRESS XXXXXXXXXXX[redacted]		6.42

AUTH 523849

REWARDS EARNED AS OF 02/08/11 = $51

M E M B E R C O P Y

0209026612031

The Membership That Pays You Back

Upgrade to a BJ's Rewards Membership and earn 2% Payback on most in-Club and all BJs.com purchases

Details at the Member Services Desk or visit BJs.com/rewards

*****

Shop BJs.com for savings on thousands of other great products! Don't miss out on emails with special offers: sign up at BJs.com.

39.22
6.42
45.64

NOTICE: PURCHASES OF LESS THAN FOUR (4) TIRES
I have been advised by a BJ's Team **Member** that tire manufacturers suggest that on new tire purchases **consisting** of less than all four(4) tires being replaced/installed at the same **time**, that the first two **NEW** tires be

SOMERSET TIRE SERVIC
343 SOUTH AVE E
WESTFIELD, NJ. 07090-1465
908-232-1300

Merchant ID: 8012889435
Term ID: 001734000801288943500O

Sale

trust thing.

XXXXXXXXXX[redacted] ★
AMEX Entry Method: Swiped
Total: $ 22.68
02/08/11 12:27:28
Inv #: 000006 Appr Code: [redacted] ★
Apprvd: Online

Customer Copy

THANK YOU!

★ Credit card # transaction code redacted per OPRA.

Experience the Difference . . .
EMPLOYEE OWNERSHIP
at **STS**

Visit our Website at www.ststire.com

ACCOUNT NO.		INVOICE DATE	INVOICE NO.

PAGE:

NTROL NO.	ORDER DATE	CUST. ORDER NO.	SLS	TERMS	DATE SHIPPED	SHIP VIA	SLS ORDER

ITEM NO.	DESCRIPTION	ORDERED		SHIPPED	QAP R F P S I	PRICE	SVC. BY	EXTENSION

eby waive ... written estimate for the requested repairs, and
orize the above re... be done along with necessary materials.
and your employees may ... above vehicle for purposes of testing.
action or delivery at my risk. It is ... that this company assumes
sponsibility for loss or damage by them
hicle placed with them for storage, sale, ... vehicle or articles left
xpress mechanic's lien is acknowledged on above ... while road testing.
o. I agree that the title to the merchandise described above to secure the amount of repairs
ıs all obligations noted herein are met and paid in full. It is understood that all parts not
rise described are new.

CUSTOMER

CUSTOMER SIGNATURE

INVOICE TOTAL

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

PINTO MARIA
Last Name, First, Middle

03-20-62
Date of Birth

[redacted]
Street Address/Mailing Address

[redacted]
City, State Zip Code

[redacted]
Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name TREEMM + BASS

Mailing Address 24 COMMERCE STREET

NEWARK N.J. 07102
City, State Zip Code

Relationship to claimant: Attorney at Law X or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A. Date 02/03/11 Time BET 5:30 + 6:00 PM

B. Describe the location or place of the accident or occurrence

ELIZABETH
Municipality

715 ELIZABETH AVE
Exact location of the occurrence

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

Client Slipped + Fell on the sidewalk
Due to ice condition caused by Scaffolding Drainage.

4. A. Claim for Damages (Check the appropriate block)

(✓) Personal Injury ( ) Property Damage
(✓) Other - Explain in detail Medical Expenses

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

Orthopedic, Neurological, Psychoneurological Injuries.

B2. Do you claim permanent disability resulting from this injury?

( ) Yes ( ) No

If yes, describe the injuries believed to be permanent.

To Be Determined

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility
Trinitas Hospital

b. Address 225 Williamson Street Elizabeth New Jersey 07207

c. Dates of treatment or services E/R 2/03/11 + E/R 2/24/11

d. Amount of charges to date To Be Determined

e. Amount paid or payable by other sources such as insurance
To Be Determined

B4. If you claim loss of wages or income as a result of the injury, state

Unemployed
Name of Employer Address of Employer

Your Occupation Date of Employment

Rate of Pay Dates of absence from work

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

6. If you claim property damage: N/A

A. Describe the property damage:

B. The present location and time when the property may be inspected:.

N/A N/A
LOCATION DATE TIME

C. Date property was acquired.

N/A

D. Cost of property.

N/A

E. Value of property at time of accident.

N/A

F. Description of damage.

N/A

G. Has the damage been repaired?

If yes, by whom, when and cost of repair.

N/A	N/A	N/A
Repaired by	When	Costs of Repairs

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

N/A

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

B. The amount of the claim.

1,000,000.00

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

City of Union
Its Servants, Employees + Agents.

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

County of Union Its Agents, Employees + Servants.

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

County of Union did not properly maintain stated property.

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

_____

_____

_____

11. State the names and address of all witnesses to the accident or occurrence.

TO BE DETERMINED

Name of Witness _____ Address _____

Name of Witness _____ Address _____

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

NONE

Name of Police Officer _____ Police Department _____

Name of Police Officer _____ Police Department _____

B. Copy of Police Report attached:
( ) Yes ( ) No

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice.

_____

_____

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

_____

_____

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

TO BE DETERMINED

_____

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

( ) Yes (X) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

A. Copies of itemized bills for each medical expense and other losses and expenses claimed.

B. Full copies of all appraisals and estimates of property damage claims by you.

C. Copies of all written reports of all expert witnesses and treating physicians.

D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.

E. Completed "Authorization for Release of Health Information", see attached form.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED: 2/24/11

Maria Pinto

Claimant or person filing claim on behalf of claimant.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: _____

Soc. Sec. Number: _____ **Date of Birth:** _____

Patient Address: _____

City / State / Zip Code: _____

My health information is to be released by the following physicians, hospitals, healthcare facilities and/or healthcare providers:

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

The health information to be released (include specific description of injury and dates of treatment):

_____

_____

_____

My health information is to be released to:

The County of Union
Office of County Counsel
10 Elizabethtown Plaza
Elizabeth, New Jersey 07207

The purpose of this disclosure is to allow the County of Union to evaluate the medical condition of the individual listed above in connection with their Tort Claim against the County. This information will be utilized by the County of Union to determine the validity and severity of any claimed medical condition for the purpose of potential settlement. The County reserves the right to have the disclosed health information evaluated by an outside physician or healthcare provider, as appropriate.

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. I understand that authorizing disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that I may obtain a copy of the information to be used or disclosed. The County of Union may not condition treatment, payment, enrollment or eligibility for health benefits on whether or not this Release is executed. I understand that I may revoke this authorization at any time by notifying the County of Union, Office of County Counsel in writing; however, this revocation will not have any effect on actions taken prior to any revocation. If this authorization is not revoked, it will terminate one year from the date of my signature. This Release is intended to comply with the Privacy Regulations enacted under the *Health Insurance Portability and Accountability Act* (HIPAA). (45 C.F.R. 164.508).

Printed Name of Patient Authorizing this Release: X Maria Pinto
(Person making claim)

Date: 2/24/11 **Signature:** X MARIA PINTO

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

Parham, Christopher Andrew — 6/12/1959
Last Name, First, Middle — Date of Birth

[redacted]
Street Address/Mailing Address

[redacted]
City, State Zip Code

[redacted]
Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name Zavodnick, Perlmutter + Boccia, LLC

Mailing Address 26 Journal Square, Suite 1102

City, State Zip Code Jersey City, NJ 07306

Relationship to claimant: Attorney at Law X or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A. Date 1/31/11 Time 5p.m approx

B. Describe the location or place of the accident or occurrence

Hillside — Municipality

Sidewalk of Liberty Ave. near Railroad tracks under Route 22 — Exact location of the occurrence

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

Claimant was walking along Liberty Avenue when he fell due to ice near train tracks that cut across Road sidewalk near Route 22 underpass. See photographs + map attached

4. A. Claim for Damages (Check the appropriate block)

(x) Personal Injury ( ) Property Damage
( ) Other - Explain in detail_____

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

Probable fracture right thumb. Injuries to neck, lower back, knee + right shoulder

B2. Do you claim permanent disability resulting from this injury?

(x) Yes ( ) No

If yes, describe the injuries believed to be permanent.

All injuries described above are claimed to be permanent

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility
Beth Israel Hospital + Beth Israel Adult Clinic

b. Address
Newark, NJ

c. Dates of treatment or services
2/3/11, 2/22/11 + other dates - still treating

d. Amount of charges to date
unknown

e. Amount paid or payable by other sources such as insurance unknown
possible Medicaid/Charity Care

B4. If you claim loss of wages or income as a result of the injury, state

Unemployed
Name of Employer

Address of Employer

Your Occupation

Date of Employment

Rate of Pay

Dates of absence from work

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

None at present.

6. If you claim property damage: Not claimed

A. Describe the property damage:

B. The present location and time when the property may be inspected:.

LOCATION DATE TIME

C. Date property was acquired.

D. Cost of property.

E. Value of property at time of accident.

F. Description of damage.

_____

G. Has the damage been repaired?

If yes, by whom, when and cost of repair.

Repaired by	When	Costs of Repairs

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

_____

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

pain + suffering + medical bills
Amounts are not known

B. The amount of the claim.

Amounts are not known

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

Unknown - but those responsible for sidewalk clearance in this area

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

unknown

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

Failure to maintain sidewalk. Allowing sidewalk to become covered with snow and ice and become a hazardous condition.

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

State of NJ, NJ Transit, County of Union
Township of Hillside

11. State the names and address of all witnesses to the accident or occurrence.

Someone I know happened to see me fall.
Name of Witness — Address

I do not know his name but I will try to get it.
Name of Witness — Address

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

None
Name of Police Officer — Police Department

Name of Police Officer — Police Department

B. Copy of Police Report attached:
( ) Yes (X) No none made

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice. See #10

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

Possibly Medicaid

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
NA		
Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

( ) Yes (X) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

A. Copies of itemized bills for each medical expense and other losses and expenses claimed.

B. Full copies of all appraisals and estimates of property damage claims by you.

C. Copies of all written reports of all expert witnesses and treating physicians.

D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.

E. Completed "Authorization for Release of Health Information", see attached form.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED: 3/2/11

Christopher D Palm

Claimant or person filing claim on behalf of claimant.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: _____

Soc. Sec. Number: _____ **Date of Birth:** _____

Patient Address: _____

City / State / Zip Code: _____

My health information is to be released by the following physicians, hospitals, healthcare facilities and/or healthcare providers:

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

The health information to be released (include specific description of injury and dates of treatment):

_____

_____

_____

My health information is to be released to:

The County of Union
Office of County Counsel
10 Elizabethtown Plaza
Elizabeth, New Jersey 07207

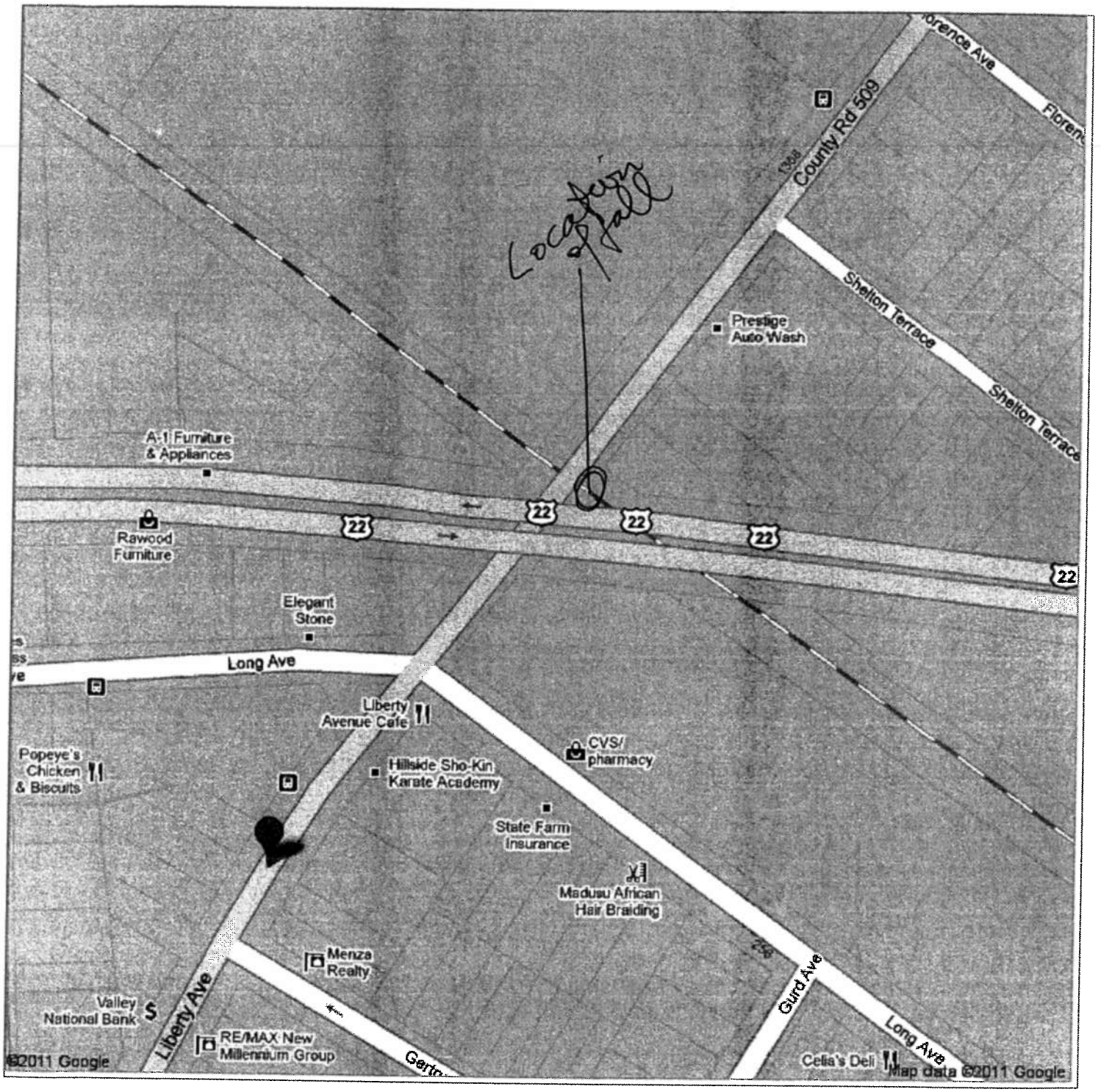
The purpose of this disclosure is to allow the County of Union to evaluate the medical condition of the individual listed above in connection with their Tort Claim against the County. This information will be utilized by the County of Union to determine the validity and severity of any claimed medical condition for the purpose of potential settlement. The County reserves the right to have the disclosed health information evaluated by an outside physician or healthcare provider, as appropriate.

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. I understand that authorizing disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that I may obtain a copy of the information to be used or disclosed. The County of Union may not condition treatment, payment, enrollment or eligibility for health benefits on whether or not this Release is executed. I understand that I may revoke this authorization at any time by notifying the County of Union, Office of County Counsel in writing; however, this revocation will not have any effect on actions taken prior to any revocation. If this authorization is not revoked, it will terminate one year from the date of my signature. This Release is intended to comply with the Privacy Regulations enacted under the *Health Insurance Portability and Accountability Act* (HIPAA). (45 C.F.R. 164.508).

Printed Name of Patient Authorizing this Release: _____
(Person making claim)

Date: 3/2/11 **Signature:** Charles A. Allen

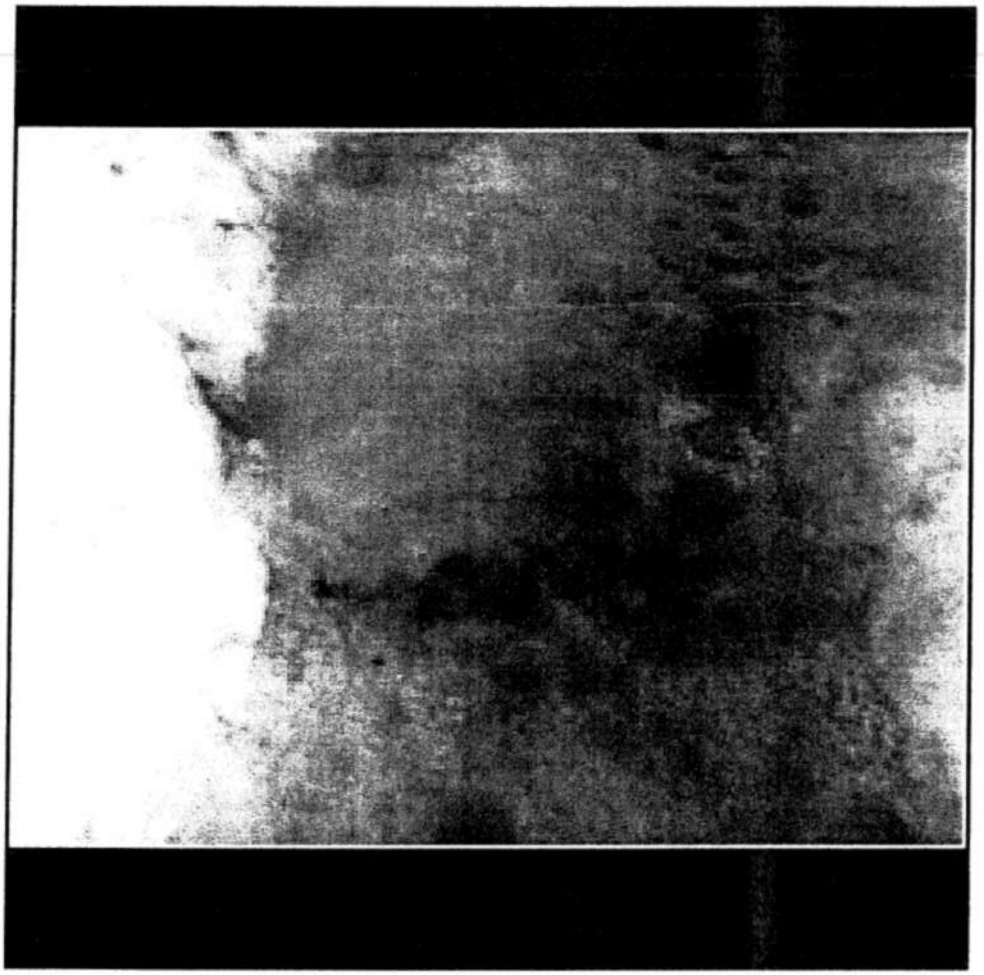
Google maps Address **Liberty Ave**
Hillside, NJ 07205



Christopher Parham

Christopher Parham

(2)



Christopher Parham

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

Rodzejewski, Suzanne
Last Name, First, Middle

10-28-69
Date of Birth

[redacted]
Street Address/Mailing Address

[redacted]
City, State Zip Code

[redacted]
Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name

Mailing Address

City, State Zip Code

Relationship to claimant: Attorney at Law ( ) or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A. Date 2/22/11 Time 9:00 am

B. Describe the location or place of the accident or occurrence

Westfield Ave, Clark
Municipality

In Front of the Knights of Columbus
Exact location of the occurrence

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

HUGE POT HOLE IN ROAD I HIT IT
Caused my Rim on my TIRE to BEND.

4. A. Claim for Damages (Check the appropriate block)

( ) Personal Injury (X) Property Damage
( ) Other - Explain in detail

Rim on my Car was Damaged due to hitting POT HOLE

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

B2. Do you claim permanent disability resulting from this injury?

( ) Yes (X) No

If yes, describe the injuries believed to be permanent.

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility

b. Address

c. Dates of treatment or services

d. Amount of charges to date

e. Amount paid or payable by other sources such as insurance

B4. If you claim loss of wages or income as a result of the injury, state

Name of Employer	Address of Employer
Your Occupation	Date of Employment
Rate of Pay	Dates of absence from work

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

—

6. If you claim property damage:

A. Describe the property damage:

Front Tire Rim Bent

B. The present location and time when the property may be inspected:.

Edison or Chanford	any date or time	
LOCATION	DATE	TIME

C. Date property was acquired.

2004

D. Cost of property.

$5000 —

E. Value of property at time of accident.

$5000 —

F. Description of damage.

Lip of The Rim Bent

G. Has the damage been repaired? yes

If yes, by whom, when and cost of repair.

Repaired by	When	Costs of Repairs
Goodyear Tire, Clark, NJ	2/25/11	$243.85

H. Attach each estimate of repair costs to this form. (see att receipt)

I. Set forth in detail the loss claimed by you for property damage.

Rim was Repaired / Allegnment done

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

See attached Receipt
Goodyear had my car for 3 1/2 days Being Repaired.

B. The amount of the claim.

$243.85

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

NJ - Union County

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

Failure to Repair pot holes
on County Road

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

County Roads damaged
caused Damage to my cat

11. State the names and address of all witnesses to the accident or occurrence.

Name of Witness /

Address /

Name of Witness

Address

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

Name of Police Officer /

Police Department /

Name of Police Officer

Police Department

B. Copy of Police Report attached:
( ) Yes (✓) No

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice.

NO

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

/

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

NO

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

( ) Yes (X) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

A. Copies of itemized bills for each medical expense and other losses and expenses claimed.

B. Full copies of all appraisals and estimates of property damage claims by you.

C. Copies of all written reports of all expert witnesses and treating physicians.

D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.

E. Completed "Authorization for Release of Health Information", see attached form.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED:

Claimant or person filing claim on behalf of claimant.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: _____

Soc. Sec. Number: _____ **Date of Birth:** _____

Patient Address: _____

City / State / Zip Code: _____

My health information is to be released by the following physicians, hospitals, healthcare facilities and/or healthcare providers:

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

NOT necessarily
No Health Ins.
was needed.

The health information to be released (include specific description of injury and dates of treatment):

_____

_____

_____

My health information is to be released to:

The County of Union
Office of County Counsel
10 Elizabethtown Plaza
Elizabeth, New Jersey 07207

The purpose of this disclosure is to allow the County of Union to evaluate the medical condition of the individual listed above in connection with their Tort Claim against the County. This information will be utilized by the County of Union to determine the validity and severity of any claimed medical condition for the purpose of potential settlement. The County reserves the right to have the disclosed health information evaluated by an outside physician or healthcare provider, as appropriate.

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. I understand that authorizing disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that I may obtain a copy of the information to be used or disclosed. The County of Union may not condition treatment, payment, enrollment or eligibility for health benefits on whether or not this Release is executed. I understand that I may revoke this authorization at any time by notifying the County of Union, Office of County Counsel in writing; however, this revocation will not have any effect on actions taken prior to any revocation. If this authorization is not revoked, it will terminate one year from the date of my signature. This Release is intended to comply with the Privacy Regulations enacted under the *Health Insurance Portability and Accountability Act* (HIPAA). (45 C.F.R. 164.508).

Printed Name of Patient Authorizing this Release: Suzanne Rodzjewski
(Person making claim)

Date: 3/2/11 **Signature:** Suzanne Rodzjewski

GOODYEAR AUTO SERVICE CENTER

INVOICE 181336

A DIVISION OF THE GOODYEAR TIRE & RUBBER COMPANY
1093 CENTRAL AVE
CLARK, NJ 07066
FEDERAL TAX ID# 340253240
(732)381-5340 HOURS 7-7MON-FRI,7-5SAT,9-4SUN
www.GoodyearAutoService.com

TIRE & SERVICE NETWORK
GOODYEAR
DUNLOP TIRES
KELLY TIRES

PAGE: 01

BILL TO: SUZANNE RODZEJEWSKI
[redacted]

PHONE 1..... [redacted] EXT.
PHONE 2.....
RETURN PARTS.. NO
PRIOR INVOICE. **NEW CUSTOMER**
DATE REQUESTED 02/22/11

VEH YEAR/MAKE. 02 MAZDA
VEHICLE MODEL. MILLENIA
VEHICLE COLOR.
LICENSE/STATE. SJJ53D / NJ
TIME REQUESTED

ODOMETER **IN**/OUT068310 / 058000
VEHICLE **IN**.....02/22/11 12:31 PM
VEHICLE **OUT**....02/25/11 05:16 PM
TERR/NONSIG....0851/900851
SALESMAN..... 002 / 024

ACCOUNT #	COB	TC	CUST#	TYPE/STATE	AUTHORIZATION	CREDIT CARD NO.	REGULAR REVLG #
085100005	P	01	07562	0 NJ	[redacted]	[redacted]	75301

SLS TECH	PRODUCT CODE	BC	QTY	DESCRIPTION	UNIT PRICE	LBR/EXCISE		LINE TOTAL
002 055	047-200 64833	R	1 1.00	ALLOY RIM MACHINING MAZDA RIM	155.00	10.00-	.00	145.00
002 055	044-268 W1	R	1 2.00	WHEEL BALANCE WARRANTY WHEEL WEIGHTS	.00		.00	FREE
002 055	041-263	R	1	NEW VALVE STEM	3.25		.00	3.25
002 055	046-377	R	1	COURTESY TIRE AND MAINTENANCE INSPECTION	.00		.00	FREE
002 055	078-145	R	1	WHEEL ALIGNMENT AUTO	.00	79.95	15.00-	64.95

SUMMARY:

PARTS TOTAL.....	158.25
LABOR TOTAL.....	79.95
SHOP SUPPLIES *	14.70
DISCOUNT LABOR.....	15.00
DISCOUNT PARTS.....	10.00
SUB TOTAL.....	227.90
SALES TAX(7.000%)	15.95

X----------
CUSTOMER AUTHORIZATION FOR TOTAL

CHARGED AMOUNT 243.85
TAXABLE AMOUNT 227.90

INVOICE TOTAL $243.85

THANK YOU FOR YOUR BUSINESS! IF YOU ARE NOT 100% SATISFIED,
PLEASE CONTACT THE STORE MANAGER, STEVEN MACE, AT (732)381-5340

SALES ASSOC(S): 002 STEVEN M.
TECHNICIAN(S): 055 DAVID W.

TREAD DEPTH L/F..... 10/32 R/F.... 10/32
TREAD DEPTH L/R..... 10/32 R/R.... 10/32

AUTHORIZED BY. SUZANNE
AUTH PHONE....
REVISED TOTAL. 227.90

AUTH REC'D BY. MICHAEL P
AUTH DATE.....
ADD'L AMOUNT.. 190.55

MANNER REC'D.. P
AUTH TIME.....
REPAIRS DESC..

ALL PARTS ARE NEW UNLESS OTHERWISE SPECIFIED
*SHOP SUPPLY FEES COVER MISC MATERIALS USED IN SERVICING YOUR VEHICLE THAT DO NOT APPEAR ELSEWHERE ON THIS INVOICE AND FOR PROFIT
SEE REVERSE SIDE FOR IMPORTANT SAFETY WARNING AND WARRANTY INFORMATION

GEORGE'S TOWING
24-HR Towing & Road Service
400 Trinity Place
ELIZABETH, NJ 07201
(908) 527-0399

Road Service

DATE 2-22-11 | TIME 10:33 A.M. / P.M. | REQUESTED BY AAA - member | P.O. NO.

NAME Suzanne Rodzynski | PHONE

ADDRESS [redacted] | CITY [redacted] | STATE | ZIP

LOCATION OF VEHICLE 20 Jackson Dr

YEAR, MAKE, MODEL MAZDA Millenia | COLOR White | DRIVER

STATE | LIC. PLATE NO. | VEHICLE I.D. NO. | REGISTERED OWNER

MILEAGE
FINISH
START
TOTAL

SERVICE TIME
FINISH
START
TOTAL

EXTRA PERSON
FINISH
START
TOTAL

REASON FOR TOW
- ☐ ACCIDENT
- ☐ ARREST
- ☐ UNREGISTERED
- ☐ TOW ZONE
- ☐ SNOW REMOVAL
- ☐ ABANDONED
- ☐ STOLEN CAR
- ☐ BREAK DOWN
- ☐ LOCK OUT
- ☐ START
- ☑ FLAT TIRE
- ☐ OUT OF GAS
- ☐ IMPOUNDED
- ☐
- ☐

SPECIAL EQUIPMENT
- ☐ SINGLE LINE WINCHING
- ☐ DUAL LINE WINCHING
- ☐ SNATCH BLOCKS
- ☐ SCOTCH BLOCKS
- ☐ DOLLY

TYPE OF TOW
- ☐ SLING/ HOIST TOW
- ☐ FLAT BED/ RAMP
- ☑ WHEEL LIFT
- ☐

TOWED PER ORDER OF
- ☐ STATE POLICE
- ☐ LOCAL POLICE
- ☑ OWNER
- ☐ DEALER

VEHICLE TOWED TO
FIRST TOW
SECOND TOW

STORAGE FROM
TO ____ DAYS @ $ ____

PAID BY
☐ CASH ☐ CHECK DRIVERS LIC. NO.
☐ CREDIT CARD ☐ MC ☐ VISA ☐ AMEX EXP. DATE
CC NO.

TOWING CHARGE	
MILEAGE CHARGE	
EXTRA PERSON	
SPECIAL EQUIPMENT	
LABOR CHARGE	
STORAGE	
SUB-TOTAL	
TAX	
TOTAL	55

OPERATOR'S SIGNATURE Macho DATE 2-22-11
TRUCK NO. 455
AUTHORIZED SIGNATURE DATE
VEHICLE RELEASED TO DATE 2-22-11

2227

Not responsible for loss or damage to vehicle in case of fire, theft or any other cause beyond our control.

Thank You

PRODUCT 2525

This is just to prove that I did get a flat this day. Not charging for this.

Suzanne Rodzynski

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

Romanko, Darlene — Jne 5, 1954
Last Name, First, Middle — Date of Birth

[redacted]
Street Address/Mailing Address

[redacted] — [redacted]
City, State Zip Code — Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name Michael A. Percario, Esq.

Mailing Address 1514 E St. George Avenue
Linden, N.J. 07036
City, State Zip Code

Relationship to claimant: Attorney at Law (✓) or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A. Date 2/15/11 Time 9:30am

B. Describe the location or place of the accident or occurrence

Union — Park Ave & Elizabeth Ave
Municipality — Exact location of the occurrence

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

I slipped on a sidewalk covered with ice on N. Park Ave near the intersection with E. Elizabeth Ave in Linden, N.J.

4. A. Claim for Damages (Check the appropriate block)

(✓) Personal Injury ( ) Property Damage
( ) Other - Explain in detail_____

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

left arm fracture, left elbow

B2. Do you claim permanent disability resulting from this injury?

( ) Yes ( ) No

If yes, describe the injuries believed to be permanent.

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility

Trinitas Hospital

b. Address

225 Williamson Street, Elizabeth, N.J.

c. Dates of treatment or services

2/5/11

d. Amount of charges to date

to be supplied

e. Amount paid or payable by other sources such as insurance

Unknown at this time

B4. If you claim loss of wages or income as a result of the injury, state

N/A
Name of Employer — Address of Employer

N/A
Your Occupation — Date of Employment

N/A
Rate of Pay — Dates of absence from work

Date returned to work N/A

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

6. If you claim property damage:

A. Describe the property damage:

B. The present location and time when the property may be inspected:.

LOCATION — DATE — TIME

C. Date property was acquired.

D. Cost of property.

E. Value of property at time of accident.

F. Description of damage.

G. Has the damage been repaired?

If yes, by whom, when and cost of repair.

Repaired by	When	Costs of Repairs

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

To be supplied

B. The amount of the claim.

To be supplied

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

to be determined

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

to be supplied

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

to be determined