CLAIM NO. _____

PERSONAL INJURY CLAIM

(PLEASE PRINT)

Your claim cannot be considered by the City until this form is fully completed. Once completed, please submit this form to the City Clerk's Department, located on the 4th floor of the Civic Centre at 99 Foster Drive. Upon receipt of your claim, you will receive an acknowledgement letter to the address provided outlining how this process will proceed.

PERSONAL INFORMATION OF CLAIMANT

First Name	**Middle Initial**	**Last Name**	
Mailing Address	**City**	**Prov.**	**Postal Code**
Primary Phone	**Secondary Phone**		**Email**

CONTACT INFORMATION (if different from Claimant's)

First Name	**Middle Initial**	**Last Name**	
Mailing Address	**City**	**Prov.**	**Postal Code**
Primary Phone	**Secondary Phone**		**Email**
Relationship to Claimant			

INCIDENT DETAILS

Date of incident: *(mm/dd/yy)* _____	**Time of incident:** _____ AM ◯ PM ◯
Address or approximate location of incident: _____	

WITNESS INFORMATION 1 (if applicable)

First Name	**Middle Initial**	**Last Name**	
Mailing Address	**City**	**Prov.**	**Postal Code**
Primary Phone	**Secondary Phone**		**Email**

WITNESS INFORMATION 2 (if applicable)

First Name	Middle Initial	Last Name		
Mailing Address	**City**		**Prov.**	**Postal Code**
Primary Phone	**Secondary Phone**			**Email**

DESCRIPTION OF INCIDENT

*Please provide **specific** information regarding the events surrounding your claim.*

ENVIRONMENTAL CONDITIONS

Please select all that apply.

Weather: ☐ Clear ☐ Rain ☐ Snow ☐ Fog ☐ Freezing Rain ☐ Hail

Light: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark

Road: ☐ Paved ☐ Unpaved ☐ Off-road

Other: _____

DESCRIPTION OF PERSONAL INJURIES

*Please provide **specific** information regarding the injuries you sustained.*

Additional space is available on the next page.

DESCRIPTION OF PERSONAL INJURIES CONTINUED

DESCRIPTION OF MEDICAL AID (if applicable)
*Please provide **specific** information regarding the medical aid you received and/or are receiving as a result of the incident.*

Did you receive care from Emergency Medical Services personnel (I.e., was an ambulance called)? ☐ Yes ☐ No

Call Number from Ambulance Call Report: _____

Have you received any other medical aid? ☐ Yes ☐ No

Health care provider's name: _____

COSTS INCURRED
What costs, if any, have you incurred as a result of this incident? Please provide supporting documentation.

Has an insurance/benefits provider been notified of the incident? ☐ Yes ☐ No

ATTACHMENTS

Please include copies of all documentation you currently have related to this incident so that your claim can be considered. Additional documentation subsequent to submitting this form should be forwarded to the City's Legal Department for further consideration.

☐ Applicable Photos ☐ Quotes/Estimates ☐ Receipts ☐ Ambulance Call Report

☐ Hospital Report/Record(s) ☐ Medical/Doctor's Report(s) ☐ Other:_____

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud, or submits an application or files a claim containing a false or deceptive statement, is guilty of fraud.

If you have any knowledge that the alleged damages might have occurred as a result of work being performed by a contractor on behalf of The Corporation of the City of Sault Ste. Marie (the "City") or a public utility, please report this information to the City Clerk's Department immediately (705-759-5388).

The personal information contained on this form shall be used solely for the purpose of processing the damage and/or personal injury claim and will be supplied to the City's insurance adjuster and/or to those from whom the City is claiming contribution or indemnity. Questions about this collection of information can be made to the City's Legal Department (705-759-5400).

Signature of Claimant: _____ **Date:** _____

UPON COMPLETING THIS FORM, PLEASE SUBMIT IT AND ALL ATTACHMENTS TO:

City Clerk's Department
Civic Centre – Level 4
99 Foster Drive
Sault Ste. Marie, ON P6A 5X6
Fax: 705-759-2310

FOR OFFICE USE ONLY

City Clerk's Department	**City Legal Department**
	Form complete: ☐ Yes ☐ No **Date returned to claimant** (if applicable): _____

Distribute: ☐ PWT ☐ Transit ☐ HR ☐ CSD ☐ ENG

☐Other: _____

Mar. 16/17