City of DeKalb
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200 South Fourth Street
DeKalb, Illinois 60115
815.748.2000 • cityofdekalb.com

LIABILITY CLAIM FORM

(PRINT/TYPE CLEARLY)

GENERAL INFORMATION

DATE OF REPORT: _____

NAME: _____

ADDRESS: _____

EMAIL ADDRESS: _____ CELL: _____ HOME: _____

DATE OF ACCIDENT: _____ TIME: _____ ☐ AM ☐ PM

LOCATION WHERE ACCIDENT OCCURRED: (be specific with ***exact*** location)

WHO WAS AFFECTED:

WHAT PROPERTY WAS DAMAGED:

PROPERTY OWNED BY AND CONTACT INFORMATION:

LIST ANY WITNESSES TO THE INCIDENT:

(ATTACH COPIES OF ALL REPORTS AND/OR INSURANCE CLAIMS, BILLS, INVOICES, PHOTOGRAPHS OR OTHER DOCUMENTARY EVIDENCE RELATING TO THIS CLAIM)

DESCRIPTION (Step-by-step, describe actions, conditions, and decisions that led to accident.)

DESCRIPTION OF EVENTS:

HAVE YOU SUFFERED ANY PHYSICAL INJURIES AS A RESULT OF THIS INCIDENT: ☐ YES ☐ NO
IF YES, PLEASE DESCRIBE YOUR INJURIES:

HAVE YOU RECEIVED ANY MEDICAL TREATMENT FOR YOUR INJURIES: ☐ YES ☐ NO
IF YES, PLEASE DESCRIBE THE MEDICAL TREATMENT RECEIVED INCLUDING THE DATE(S), LOCATION(S), AND PHYSICIAN(S) WHO PROVIDED THIS TREATMENT: (Add additional pages if needed)

HAVE YOU MADE A CLAIM AGAINST ANY OTHER PERSON OR ENTITY FOR THIS INCIDENT: ☐ YES ☐ NO
IF YES, STATE THE NAME, ADDRESS AND TELEPHONE NUMBER OF THAT PERSON OR ENTITY:

HAVE YOU SUBMITTED THIS CLAIM TO ANY INSURANCE COMPANY: ☐ YES ☐ NO
IF YES, STATE THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE INSURANCE COMPANY:

WHAT ARE YOU REQUESTING FROM THE CITY OF DEKALB:

COMPLETED BY:_____ _____
SIGNATURE DATE

(Rev. 09/2017)