STATE OF FLORIDA DEPARTMENT OF TRANSPORTATION

STATEMENT OF CLAIM
FOR BODILY INJURY & PROPERTY DAMAGE

Office of the General Counsel, Department of Transportation, 605 Suwannee Street, MS 58, Tallahassee, FL 32399-0458
dotclaims.review@dot.state.fl.us

FILE NO. _____
(do not complete)

INCIDENT	Date: _____ Time: _____ ☐ AM ☐ PM Specific Location: _____ (street, city, county) Type of Claim: Bodily Injury _____ Property Damage _____ Description: _____
INJURED PERSON	Name: _____ Age: _____ Address: _____ City: _____ State: _____ E-Mail (Optional): _____ Phone No.: (Home) _____ (Work) _____ (Cell) _____ Occupation and Employer: _____ Why on Premises: _____ Nature and Extent of Injury: _____
INJURED PERSON	Name: _____ Age: _____ Address: _____ City: _____ State: _____ E-Mail (Optional): _____ Phone No.: (Home) _____ (Work) _____ (Cell) _____ Occupation and Employer: _____ Why on Premises: _____ Nature and Extent of Injury: _____
PROPERTY DAMAGE IF APPLICABLE	Owner and Address: _____ _____ Telephone No.: _____ Description of Property: _____ Describe Damage: _____ When/Where Property can be Inspected: _____
WITNESSES	NAME ADDRESS TELEPHONE NO. _____ _____
LAW ENFORCEMENT REPORT	Identify Law Enforcement Agency Investigating: _____ Date of Report: _____ Report No.: _____ If available, please provide a copy.

TREATMENT AND BILLING	List all doctors, hospitals, or facilities giving treatment (include complete name and address): _____ _____ _____ Amount of total doctor(s) bill(s): _____ (Itemized bills must be attached) Hospital bill(s): _____ (Itemized bills must be attached) Are you presently receiving medical treatment? ☐ Yes ☐ No
EMPLOYMENT	Were you in the course of your employment when the incident happened? ☐ Yes ☐ No Did you lose income? ☐ Yes ☐ No (If yes, list employers of past 3 years) NAME ADDRESS PHONE 1. _____ _____ _____ 2. _____ _____ _____ 3. _____ _____ _____ (Lost wages must include a signed statement from employer itemizing dates and amount of pay lost.) Date inability to work began: _____ Date returned to work: _____ List any other expenses (nurses, prescriptions) and enclose supporting bills. _____ _____ Do you have any existing claim for workers' compensation, personal injury protection, or personal injury? ☐ Yes ☐ No (If yes, list date, place, type of claim and incident, injury incurred, and other parties involved): _____ _____ (Use back if needed)
PREVIOUS CLAIMS	List any incident in which you received any type of injury in the past 5 years. If none, indicate "none": _____ _____ (Use back if needed) Identify law enforcement agency investigating: _____

UNDER SECTION 817.234, FLORIDA STATUTES, WHICH APPLIES TO THIS CLAIM, ANY PERSON WHO FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER IS GUILTY OF A FELONY.

_____ _____

DATE SIGNATURE OF PERSON FILING CLAIM