DEPARTMENT OF ADMINISTRATION
RISK MANAGEMENT

CLAIM REPORT AND DEMAND

This claim form must be filled out by the person making the claim against the State and/or its employees. It is to be returned within 10 days to:

_____@state.mn.us

OR

State of Minnesota Office of Risk Management
310 Centennial Office Building
658 Cedar Avenue
St. Paul, MN 55155

1. CLAIMANT

Name of Claimant	Date of Birth
Home Address	Home Telephone
City, State, Zip Code	Business Telephone

2. INCIDENT OR OCCURRENCE

Date	Time (a.m./p.m.)
Location (as exact as possible)	City, State
Weather Conditions	Lighting conditions

Describe the incident or occurrence in detail:

Full names and addresses of all witnesses:

a. _____

b. _____

c. _____

Full name and addresses of each state agency and each state employee whom you claim caused your damages or injuries:

a. _____

b. _____

c. _____

Full name and address of all other persons, companies, or governmental agencies that you claim are responsible for your damages or injuries:

a. _____

b. _____

c. _____

State the cause of the incident or occurrence:

3. DAMAGES OR INJURIES

Full name and address of each injured person on whose behalf claim is here made (hereinafter "the injured person"):(If the injured person is a minor, include the birthdate and the name(s) of parent(s) or legal guardian(s))

Full name and address of other person(s) suffering injuries, if any:

a. _____

b. _____

c. _____

Describe the injury, damages and losses incurred by the injured on whose behalf claim is made:

What was the injured doing at the time of the incident:

If injury or damage was to property, state in detail the following:

a. What was damaged:

b. Name of Manufacturer: _____

c. How old was the property at the time of the incident or occurrence?: _____

d. What condition was the property in at the time of the incident or occurrence?

e. Any prior damage: If so, describe:

f. Where purchased: _____

g. If other than claimant, who owned it at the time of the incident:

h. Any liens, mortgages, attachments, security interests if third party rights of claims outstanding on said property? If yes, state name and address.

i. Estimated cost of repair: _____

j. Where is the damaged property now located:

If injury or damages were to the person injured, state the following:

a. Identify any health care facility, including address and telephone number, at which the injured person receive care related to the incident or occurrence:

b. Identify the full name, address, and telephone number for each health care provider from whom the injured person received care related to the incident or occurrence:

c. If the injury arose out of or in the course of the injured person's employment, please identify the injured person's employer and describe the circumstances under which the injury occurred:

If there is any type of insurance available for any damages claimed by any injured person, please identify the insurance company and type of insurance coverage available:

State the amount hereby claimed and demanded by you from the State: _____
State the basis of the calculation of this amount:

Have you made any other claims against the State and/or its employees? _____
If so, state the date(s) and circumstances:

I hereby certify that the foregoing statements and claim made by me are true. I am aware that if any statement made herein is to my knowledge false, in whole or in part, that I am subject to punishment provided by law.

_____ _____

Date Signature of Claimant