## CLAIM AGAINST THE STATE OF NEVADA

TO:	Claims Mana	ager	Received By AG's Office: For AG's Office Use Only:				
	Office of the Attorney General DMV Legal/Tort Claims 555 Wright Way Carson City, NV 89711 (775) 684-1252 or (775) 684-1263			Claim # X-Ref DOL B/A Agency	\$		
need r should record	more space, att d be attached i ds. PLEASE P	nation is necessary to fairly tach a separate sheet of pay of available. However, such RINT LEGIBLY OR TYPE.	oer. Additional evidend additional evidence w You <u>must sign the clair</u> 'O MAKE A CLAIM PRI	ce, such as photog ill not be returned n form. OR TO FILING A I	raphs, police reports, etc.  l. Keep copies for your  LAWSUIT.		
<ul><li>Yo</li><li>Yo</li></ul>	our Client is the our Company is t	ant if you are making this clair claimant if you are an attorned the claimant if you are making appany is the claimant if you re	y making a claim on beha a claim on behalf of a bus	siness.			
1.	CLAIMANT'S ADDRESS	NAME					
	DATE OF BIR	RTH o receive correspondence via E	DAYTIME TELEPHONE MAIL instead of U.S. Ma		ur email address:		
2.	IF CLAIMAN	IF CLAIMANT IS A BUSINESS: Name of Employee involved in incident					
	Company Con			Your Reference			
3.	IF CLAIMANT IS AN INSURANCE COMPANY: Name of your "INSURED"						
	Claim Represe	entative	Your	Claim No.			
4.	<b>IF YOU ARE REPRESENTED BY AN ATTORNEY:</b> We will only communicate with you through your attorney. It is not necessary to retain an attorney to file a claim; however, if you have an attorney <i>for this claim</i> , please provide the following information:  Attorney's Name						
	Firm's Name						
	Address						
	Phone Number	r:	File F	Reference			
5.	DATE AND TIME when the incident occurred:						
6.	Exact LOCATION where the incident occurred:						
7.	IF THIS IS AN AUTOMOBILE ACCIDENT, please supply the following information:						
	YOUR VEHICLE						
	Year STATE VEHIO	Make CLE	Model	Licer	nse Number		
	Year	Make	Model	Licer	nse Number		

9.	A CLAIM FOR \$	is hereby	y made against the STATE OF N	YEVADA, based upon the following facts:			
10.	Describe how damage or injury occurred and what the STATE OF NEVADA or its employees did to cause your damage or injury. <b>Give full details:</b>						
	A) State of NV Employee's I		B) State of N				
11.	= = = = = = = = = = = = = = = = = = = =	_	s you have claimed. Please provie clude any rental bills, receipts, n	de a MINIMUM OF 2 REPAIR nedical reports, itemized statements, etc.			
12.	covered under any type o	of Medicare Prostate of NV, you	ogram. NO YES if y	nust answer this question: <b>Are you</b> es: Pursuant to Federal Medicare rules, if to provide your Medicare Health			
except that T IF MY RELE BEFO	t those matters stated upor HIS IS MY ENTIRE CLAIM CLAIM IS PAID BY THE S ASE OF ALL CLAIMS IN T	aim and know an information and I AGAINST THI STATE OF NEV THE PRESENCHE OFFERED TO	the contents thereof, that the and belief, and as to those ma E STATE OF NEVADA. ADA, I FULLY UNDERSTAN E OF A NOTARY PUBLIC FOR TO ME. THIS RELEASE WILL	that I am the claimant named above, e same is true of my own knowledge, tters, I believe them to be true, and D THAT I WILL HAVE TO SIGN AR THE DETERMINED AMOUNT L BECOME EFFECTIVE ONLY			
Signat	ure of Claimant (or Company	Representative)	Date				
		_		ingly presents a false claim is guilty of ne year, and a fine of up to \$2,000.			
Incon	nplete or unsigned clain	n forms will n	ot be accepted and will be	returned.			
Claim	s may be submitted as fo	ollows:					
	Email: agclaims@ag.	.nv.gov	Mail: Claims Manager DMV Legal/Tort Claims 555 Wright Way Carson City, NV 89711	Fax: 775-684-4601			

State the full names, addresses and phone numbers of all witnesses:

8.