NOTICE OF TORT CLAIM

TO: [Name of Government Entity/Agency]
[Address of Agency]
[City, State, Zip Code]

DATE: [Current Date]

1. CLAIMANT INFORMATION
Name: [Full Name of Injured Party]
Address: [Current Address]
Phone Number: [Phone Number]
Date of Birth: [DOB]

2. REPRESENTATION (If applicable)
Attorney Name: [Attorney Name/Law Firm]
Address: [Firm Address]
Phone Number: [Firm Phone Number]

3. DATE AND LOCATION OF INCIDENT
Date of Incident: [Date of Medical Treatment/Injury]
Location: [Name of Hospital or Clinic and Address]

4. DESCRIPTION OF INCIDENT
[Provide a concise statement of the facts regarding the medical treatment received and how the malpractice occurred. Identify the healthcare providers involved.]

5. BASIS OF LIABILITY
[Briefly describe why the government entity or its employees are responsible for the injury, such as negligence, failure to diagnose, or surgical error.]

6. DESCRIPTION OF INJURIES AND DAMAGES
[Detail the physical and emotional injuries sustained, ongoing medical treatments, and any permanent disabilities.]

7. AMOUNT OF CLAIM
Total Amount Claimed: $[Dollar Amount]
Breakdown (if known):
- Medical Expenses: $[Amount]
- Lost Wages: $[Amount]
- Pain and Suffering: $[Amount]

8. SIGNATURE

_____

[Claimant or Attorney Signature]

_____

[Printed Name]