



NEW YORK CITY DEPT. OF EDUCATION
MEDICAL, LEAVES & BENEFITS OFFICE

65 COURT STREET,
ROOM 101
BROOKLYN, NY 11201

CLAIM FOR
LOSS OR DAMAGE
OF PERSONAL
PROPERTY

SEE REVERSE SIDE FOR INSTRUCTIONS

PLEASE PRINT OR TYPE

NAME: _____ SOCIAL SECURITY NUMBER _____

MAILING ADDRESS: _____ FILE NUMBER: _____

1. TITLE: _____ 2. SCHOOL OR OFFICE _____

3. SCHOOL/OFFICE ADDRESS: _____

4. ROOM NUMBER OR PLACE OF LOSS OR DAMAGE: _____ DATE AND TIME _____

5. DATE AND TIME REPORTED TO PRINCIPAL OR HEAD OF BUREAU: _____

6. WAS INCIDENT REPORTED TO THE POLICE? YES NO

7. DETAILED DESCRIPTION OF INCIDENT: (CONTINUE ON REVERSE SIDE, IF NECESSARY) _____

8. ITEMS CLAIMED: (COMPLETE ON REVERSE SIDE, IF NECESSARY)

ARTICLE	COST	DATE PURCHASED	STORE & LOCATION

9. REIMBURSEMENT FOR PERSONAL PROPERTY IS LIMITED TO \$100.00 PER PERSON IN ANY SCHOOL YEAR. CASH IS NOT REIMBURSABLE. ONLY THE LOSS OR DAMAGE TO PERSONAL CLOTHING AND PERSONAL ACCESSORIES (I.E., HANDBAGS, WALLETS, EYEGASSES, OR UMBRELLAS) ARE REIMBURSED.

10. IF DAMAGE HAS BEEN REPAIRED, INDICATE THE COST OF REPAIRS: \$ _____ 11. TOTAL AMOUNT CLAIMED: \$ _____

12. DO YOU HAVE A HOME OWNER'S POLICY OR ANY OTHER PRIVATE INSURANCE THAT WOULD COVER EITHER FULL OR PARTIAL REIMBURSEMENT OF YOUR LOSS?

YES NO IF YES, FURNISH FOLLOWING: _____

NAME, ADDRESS OF COMPANY, AND POLICY NUMBER (SEE PARAGRAPH 1C INSTRUCTIONS)

13. THE FACTS CONTAINED ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF. I UNDERSTAND THAT THE ACCEPTANCE OF PAYMENT FOR THE AMOUNT ALLOWED BY THE BOARD OF EDUCATION FOR THIS CLAIM SHALL RELEASE THE BOARD OF EDUCATION FROM ALL LIABILITY FOR THE LOSS OR DAMAGE TO PERSONAL PROPERTY ARISING OUT OF THE INCIDENT DESCRIBED ABOVE. I ALSO AGREE THAT IN THE EVENT THAT LOST PROPERTY IS LATER RECOVERED AND SAME IS RETURNED TO ME, I SHALL REIMBURSE THE BOARD OF EDUCATION FOR ANY MONIES PAID.

SIGNATURE OF CLAIMANT

DATE

14. CERTIFICATE BY PRINCIPAL OR BUREAU HEAD

THE FACTS CONTAINED UNDER ITEMS 1 THROUGH 8 ARE SUBSTANTIALLY CORRECT. ANY EXCEPTIONS ARE NOTED BELOW:

CHECK ONE APPROVAL RECOMMENDED

DISAPPROVAL RECOMMENDED FOR THE FOLLOWING REASON: _____

EXCEPTIONS: _____

SIGNATURE

DATE

PRINT NAME

MAKE NO ENTRY BELOW THIS LINE

DATE APPROVED _____ AMOUNT \$ _____ FOR CLAIMS UNIT

DATE DISAPPROVED _____