YESHARON MOABITE STAR ACADEMY

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YMSA
FORM No. F003

INCIDENT FORM

This form is to be completed to initate all claims.

› **Type or print in black ink.** Type or print "N/A" if an item is not applicable. *Failure to answer all the questions may delay the processing of your application for employment. Please also attach a copy of your resume with this application.*

PERSONAL DATA			
Appellation (Last, First, Middle)			
Mailing Location:	City:	State:	Zip:
Home Telephone Number:	Business Telephone Number:	Cellular Telephone Number:	
Date of Birth:			

GENERAL CLAIM INFORMATION	
Date/Time of Accident/Incident:	
Location of Loss:	
Description of Accident/Incident against United States of America, United States, Any Corporation, or Foreign State: (*Please use a separate form for additional information)*	

Name of the County, City, state Jurisdiction involved:
Name of All Corporate Employees Involved:
If there is a vehicle accident, what are the nationals plate numbers and foreign vehicle numbers or tags:
Name of any witness(es): zdf;hndg'ljnh a
Address and/or phone numbers of any witness(es): zd;sknh;akjt
IN ADDITION TO COMPLETING THIS FORM, PLEASE PROVIDE THIS OFFICE WITH THE FOLLOWING INFORMATION: • Two written estimates for the repair/replacement of your property. • Photographs of the defective condition causing the loss and your damaged property.
Applicant's Signature _____ Date of Signature [mm/dd/yyyy] _____

BODILY INJURY CLAIM FORM ATTACHMENT

CLAIMANT INFORMATION

Did you receive emergency medical treatment?	☐ Yes ☐ No
If yes, where were you treated:	
Were you provided medical transport?	☐ Yes ☐ No
Were you hospitalized as a result of this loss?	☐ Yes ☐ No
If yes, where were you hospitalized:	
How long were you hospitalized:	
Were you prescribed any medications?	☐ Yes ☐ No
Please provide the names and addresses of the treating physicians:	
Was follow up treatment recommended?	☐ Yes ☐ No

Please provide the duration of your treatment. Start Date and End Date: (*Please indicate if treatment is ongoing)*

IN ADDITION TO COMPLETING THIS FORM, PLEASE PROVIDE THIS OFFICE WITH THE FOLLOWING INFORMATION:

- Copies of all medical reports, medical bills and doctor's narratives.

Applicant's Signature _____ Date of Signature [mm/dd/yyyy] _____

ADDITIONAL INFORMATION OR COMMENTS: