

**CITY OF HAMILTON**  
One Renaissance Center  
345 High Street, Suite 710  
Hamilton, Ohio 45011  
Phone: 513-785-7180  
Fax: 513-785-7187

**CLAIM FORM FOR PERSONAL INJURY**

*Please print clearly...*

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of incident leading to this claim \_\_\_\_\_ Time \_\_\_\_\_ AM/PM

Identify the location where incident occurred \_\_\_\_\_

Give details of incident from which personal injury resulted: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Total amount of medical expenses incurred (*attach copy of medical bills*): \_\_\_\_\_

\_\_\_\_\_

Name and address of owner of property where incident occurred: \_\_\_\_\_

\_\_\_\_\_

Was the incident from which the personal injury resulted reported to the City? \_\_\_\_\_

Please identify any City personnel or other persons who witnessed the event causing the personal injury or who viewed the incident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Return completed form to Law  
Department at the above address.*

\_\_\_\_\_  
Claimant's Signature