

CLAIM FORM

Claim No	
Date Submitted:	

INSTRUCTIONS FOR COMPLETING THIS FORM

Please fill out all of the requested information. If something does not apply to you, include DNA in the appropriate space.

If request is to include replacement uniforms, tools, flashlights and the like, all copies of receipts must accompany the original claim. If additional space is required to complete this claim, feel free to attach any and all documentation to support your claim request.

Attach all receipts for uniforms or equipment. Attach all copies of payroll stubs, time sheets and any or all other documentation which will provide proof of time lost by injured officer or spouse.

The original copy of this claim must be submitted to your department representative. The IPOF will not disburse any funds without the original cliaim. The maximum claim for any one injury/occurrence is \$10,000 (ten thousand dollars).

It is the responsibility of your department representative to check your claim for discrepancies and to make the necessary corrections prior to being submitted to the entire board.

INJURED OFFICER INFORMATION CLAIMANTS AGENCY

It is the sole discretion of the board of directors to approve or disapprove all or part of any claim submitted.

CLAIMANT'S ENFORCEMENT AGENCY				
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FIRST NAME		MIDDLE		
	CONTACT PHONE H W	C P		
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ABLE				
ACCIDENT INJURY INFORMATION				
	Time of Incid	ent:		
	WORKER'S COMPENSATIO	N NUMBER (CLAIM NUMBER)		
OMMENDATIO	NS OF DEPART	TMENT REPRESENTATIVE		
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