FORM 1420 (10/15)

STATE OF NEW YORK – DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION

EMPLOYEE CLAIM FORM

This form is to be used by employees, visitors, and volunteers.

PART 1: EMPLOYEE CLAIM

1. EMPLOYEE'S NAME (LAST, FIRST, MIDDLE)	2. TITLE	3. FACILITY	4. SOC. SEC. NUM.	5. DATE

6. DEPRECIATION SCHEDULE ITEM NAME AND DESCRIPTION	ORIGINAL COST	DEPREC. AGE	CONDITION	SALVAGE RATE	INSURANCE VALUE	REIMBURSEMENT	REIMBURSEMENT REQUESTED
	$			%	$		$
BARGAINING UNIT REQUESTED _____						TOTAL AMOUNT	$

7. DESCRIPTION OF INCIDENT LEADING TO LOSS, INCLUDING ITEMS, PERSONS OR SITUATIONS CAUSING INCIDENT, WITNESS AND OTHER INFORMATION PERTINENT TO THE CLAIM:

I certify that the loss which has resulted in this claim occurred through no fault of my own

_____
(SIGNATURE OF CLAIMANT)

PART 2 : STATEMENT BY WITNESS

_____
(SIGNATURE OF WITNESS)

PART 3 : ADMINSTRATIVE REVIEW AND RECOMMENDATION

I certify that I have personally examined the claim items belonging to _____. In consideration of the information indicated above, I hereby recommend this claim for reimbursement under the provisions of State Finance Law, Section 8, subdivision _____ in the amount of: $

_____
(SIGNATURE OF DSA/AREA SUPERVISOR OR DESIGNEE)

PART 4: ADMINISTRATIVE APPROVAL

I have examined the application of the claimant; and the facts concerning the incident for which the claim is being made, to my knowledge, are true and correct, that damage or loss was sustained in the proper performance of duty and through no fault of the claimant, and the application (should be) (is hereby) approved for reimbursement in the amount": $

_____
SIGNATURE OF SUPERINTENDENT/REGIONAL DIRECTOR.)

PART 5: REVIEW BY BUDGET & FINANCE, CENTRAL OFFICE

COMMENTS:

☐ APPROVED

☐ DISAPPROVED

_____
(SIGNATURE) (TITLE) (DATE)