

CLAIM INVESTIGATION REPORT

FACILITY CLAIM #

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FAC. ID #

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SEQ. NUM.

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1. INMATE NAME	2. DEPT. I.D. #	3. FACILITY NAME	4. CELL/BLOCK	5. DATE
6. LOCATION WHERE LOSS TOOK PLACE	7. TIME/DAY	8. PERSON(S) RESPONSIBLE		
9. WITNESS' NAME & TITLE OR IDENTITY			10. WITNESSED BY YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO	
11. WITNESS' STATEMENT RE CLAIM				
12. CIRCUMSTANCES INCLUDING REASON/CAUSE				
13. NAME OF EVALUATOR(S) & STATEMENTS, IF ARTS & CRAFTS, ETC.				
14. INSURANCE COVERAGE? WITH WHOM? TYPE OF COVERAGE?  <input type="checkbox"/> YES <input type="checkbox"/> NO				
15. CLAIM INVESTIGATOR'S RECOMMENDATION/COMMENTS:				
16. CLAIM INVESTIGATOR'S SIGNATURE		TITLE		DATE