New York City Comptroller
Brad Lander

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007
Form Version: NYC-COMPT-BLA-HC-LE3

City Employment Claim Form

For most claims, a claim must be filed in person or by registered or certified mail within 90 days of the occurrence at the NYC Comptroller's Office, located at 1 Centre Street, Room 1225, New York, NY 10007. The claim form must be notarized. If the claim is not resolved within one (1) year and 90 days of the occurrence, you must start a separate legal action in a court of law before the expiration of this time period to preserve your rights.

TYPE OR PRINT

I am filing: ☐ On behalf of myself.

☐ On behalf of someone else. If on someone else's behalf, please provide the following information:

Last Name:
First Name:
Relationship to the claimant:

Claimant Information

*Last Name:
*First Name:
*Address:
Address 2:
*City:
*State:
*Zip Code:
*Country: USA
Date of Birth: *Format: MM/DD/YYYY*
Soc. Sec #:
*Phone:
*Email Address:

Occupation:
Current City Employee? ☐ Yes ☐ No ☐ NA
Current Agency:

Gender: ☐ Male ☐ Female ☐ Other

☐ Attorney is filing.

Attorney Information (if represented by attorney)

+Firm or Last Name:
+Firm or First Name:
+Address:
Address 2:
+City:
+State:
+Zip Code:
Tax Id:
+Phone:
+Email Address:

The time and place where the claim arose

*Incident Date from: *Format: MM/DD/YYYY*
*Incident Date to: *Format: MM/DD/YYYY*
*Incident Location:
Address:
Address 2:
City:
State:
Borough:

** Denotes required fields.*
\+ Denotes field that is required if Attorney is filing.

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***Nature of Claim/Description of Claim**

Attach extra sheets if more room is needed.

What agency/employer are you making this claim against?

*Agency:
Address:
Address 2:
City:
State:
Zip Code:

Work days lost:
Amount Earned Weekly:
Amount Earned Yearly:

Were you employed by a City Contractor at the time of claimed occurrence? ☐ Yes ☐ No

++Contractor Name:

**Denotes required field*
++Denotes field that is required if you were employed by a City Contractor.

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Salary/Benefit Claimed Damages

	Date From:	Date To:	Amount:
Overtime:			
Compensatory time:			
Differential:			
Annual Leave/Vacation:			
Sick Leave:			
Salary:			
		Total:	

Additional Claimed Damages

		Amount:
Specify:		
Specify:		
Specify:		
Specify:		
Specify:		
	Total:	

***Total Claimed Amount:**

Date _____ Signature of Claimant _____

State of New York, County of _____

I, _____ being duly sworn depose and say that I have read the foregoing NOTICE OF CLAIM and know the contents thereof: that same is true to the best of my own knowledge, except as to the matter here stated to be alleged upon information and belief, and as to those matters. I believe them to be true.

Sworn before me this day _____

Signature of Claimant _____ Signature of notary _____

**Denotes field that is required.*