

INSTRUCTIONS:
Place only **ONE** letter or number in each space
and leave a blank space between words.

**CIVIL COURT OF THE CITY OF NEW YORK
SMALL CLAIMS PART
STATEMENT OF CLAIM**

(FOR OFFICE USE ONLY)

I. CLAIMANT'S INFORMATION

(Your)

LAST NAME _____

FIRST NAME _____ MIDDLE INITIAL _____

ADDRESS
(NO P.O. BOX) _____

BOROUGH, CITY, STATE ZIP
TOWN OR VILL. _____

OTHER INFO _____

[Doing Business As] [In Care Of]

PHONE NO. _____

[Attention To] **Circle One**

II. DEFENDANT'S INFORMATION*

(Their)

LAST NAME _____

(or Full Business Name)

FIRST NAME _____ MIDDLE INITIAL _____

ADDRESS
(NO P.O. BOX) _____

BOROUGH CITY, STATE N | Y ZIP _____
TOWN OR VILL. _____

OTHER INFO _____

[Doing Business As] [In Care Of]

PHONE NO. _____

[Attention To] **Circle One**

III. CLAIM

Amount Claimed: \$ _____ (Maximum \$5,000) Date of Occurrence or Transaction: _____

Place of occurrence, if Auto Accident

PRIMARY REASON FOR CLAIM (Check One):

- | | | | | |
|----------------------------|--|--|---|--|
| Damage caused to: | <input type="checkbox"/> automobile | <input type="checkbox"/> other personal property | <input type="checkbox"/> real property | <input type="checkbox"/> person |
| Failure to provide: | <input type="checkbox"/> proper repairs | <input type="checkbox"/> proper services | <input type="checkbox"/> proper merchandise | <input type="checkbox"/> goods paid for |
| Failure to return: | <input type="checkbox"/> security | <input type="checkbox"/> property | <input type="checkbox"/> deposit | <input type="checkbox"/> money loaned |
| Failure to pay: | <input type="checkbox"/> salary | <input type="checkbox"/> for services rendered | <input type="checkbox"/> insurance claim | |
| | <input type="checkbox"/> rent | <input type="checkbox"/> commissions | <input type="checkbox"/> for goods sold and delivered | |
| Breach of. | <input type="checkbox"/> contract | <input type="checkbox"/> lease | <input type="checkbox"/> warranty | <input type="checkbox"/> agreement |
| Loss of: | <input type="checkbox"/> luggage | <input type="checkbox"/> property | <input type="checkbox"/> time from work | <input type="checkbox"/> use of property |
| Returned: | <input type="checkbox"/> check (bounced) | <input type="checkbox"/> check (stopped) | | |
- Other:** (Be brief) _____

IDENTIFYING NUMBER(S) - (Receipt #, Claim #, Account #, Policy #, Ticket #, License #, Plate #'(s)) _____

Today's Date _____

Signature of Claimant or Agent _____

CERT'D # _____

COA CODE _____

CLAIM AMT. _____

\$ _____

FEE _____

STANDARD FEE

CLAIMANT V. DEFENDANT

NO FEE

DEFENDANT V. THIRD PARTY

CLAIMANT V. ADD'L DEFENDANT

POSTAGE ONLY

WAGE CLAIM TO \$300

LANGUAGE _____

DATE DATA ENTERED _____

DATE NOTICES MAILED _____

CASE TYPE:

MULTI DFT CTR/CLM

3 PARTY CRS/CMPLT

FIRST DATE _____

DAY COURT

STATUTORY OTHER

* DEFENDANT'S NAME: The **legal** name will be required in order to obtain an enforceable judgment. If the Defendant is a **business**, its full and correct **business name** should be obtained from the

Office of the County Clerk in the county in which the business is located or check on the following website: www.dos.state.ny.us.

DEFENDANT'S ADDRESS: YOU must indicate the proper street address of the Defendant. A Post Office Box is not acceptable.

FREE CIVIL COURT FORM

No fee may be charged to fill in this form.

Form can be found at