Georgia Department of Corrections Claim of Loss

Employee: _____
Facility: _____
Address: _____
Report: _____
Date of Occurrence: _____
Position Number: _____
Employee ID Number: _____

Description of Item		Replacement Value OR Repair Cost
	Total Amount of Claim	
	Approved Claim Amount	

Description of Cause or Action for Claim: _____
_____
_____
_____
_____
_____
_____
_____
_____

Employee Signature:	Care & Custody Manager:
Regional Business Mgr./ DW of Admin. Signature:	Budget Code:
Warden/Supt. Signature:	Acct. Code:

Retention Schedule: Upon completion, this form and any receipts pertaining to this procedure shall be retained for five (5) years.