Georgia Department of Corrections Claim of Loss

Employee : _____
Facility: _____
Address:_____
Report:_____
Date of Occurrence : _____
Position Number : _____
S/S 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 Unit:
Business Mgr. Signature:	Budget Code:
Warden/Supt. Signature:	Acct. Code: