

Town of Fairfax



12 Buck Hollow Road
Fairfax, VT 05454
(802) 849-6111

Claim for Mailbox Damage

NAME _____ DATE _____

ADDRESS _____

PHONE _____ EMAIL _____

A. Incident Information

Date/time of Incident: _____

Description:

Claim for: Mailbox only Post only Mailbox & Post

B. Witnesses

Please Identify all witnesses to the incident, if any, by name, address, and telephone number (if available).

C. Additional Comments

(signature of claimant)