

**Schedule of Special Damages**

**Claim Number:** \_\_\_\_\_

Claimant name: \_\_\_\_\_

Date of accident: \_\_\_\_\_

Type	Amount Claimed
Application Fee	
Cost of medical report submitted with Application	
Loss of earnings – please tick the relevant box	<div> <div>No loss of earnings</div> <div>Loss of earnings certificate attached</div> <div>Loss of earnings certificate to follow</div> <div> <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/> </div> </div>

**Please attach supporting receipts/vouchers**

I confirm that the details above are correct and represent the full extent of my claim for Special Damages in respect of an accident which occurred on «Date\_of\_Incident». I have not received payment for any of the amounts claimed from the respondent or their insurers.

Signed: \_\_\_\_\_  
(Claimant)

Date: \_\_\_\_\_