4025642

FORM B10 (Official Form 10)

UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

PROOF OF CLAIM
Chapter 11

In Re Kmart Corporation, et al.

Case Numbers 02-02462 through 02-02499

Name of Debtor: (see attached for complete list of debtors)
KMART CORPORATION

Case Number: 02-02474

NOTE: This form should not be used to make a claim for an administrative expense arising after the commencement of the case. A "request" for payment of an administrative expense may be filed pursuant to 11 U.S.C § 503.

Name of Creditor (The person or other entity to whom the debtor owes money or property):

11 2374400

KENDRICK, GERALD
1416 MEADOW ST.
METAIRIE, LA 70003

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.
☐ Check box if you have never received any notices from the bankruptcy court in this case.
☐ Check box if the address differs from the address on the envelope sent to you by the court.

Your claim is scheduled as follows:

Class
UNSECURED NON PRIORITY

Amount
CONTINGENT, DISPUTED, UNLIQUIDATED

10081829

This Space is for Court Use Only

If address differs from above, please complete the following:
Creditor Name: GERALD KENDRICK
Telephone: # 504-738-9067
Address: 1416 MEADOW ST.
City/St/Zip: METAIRIE, LA 70003-5924

Account or other number by which creditor identifies debtor:

Check here if this claim ☒ replaces ☐ amends a previously filed claim, dated 09-29-2001

1. Basis for Claim
☐ Goods sold
☐ Services performed
☐ Money loaned
☒ Personal injury/wrongful death — HOSPITAL BILL # 379.50
☐ Taxes
☐ Other

☐ Retiree benefits as defined in 11 U.S.C. §1114(a)
☐ Wages, salaries, and compensation (fill out below)
Your SS #: _____
Unpaid compensation for services performed
from _____ (date) to _____ (date)

2. Date debt was incurred:
SEPTEMBER 29, 2001

3. If court judgment, date obtained:
JULY 31, 2002

4. Total Amount of Claim at Time Case Filed: $ 379.50
If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 below.
☐ Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.

5. Secured Claim.
☐ Check this box if your claim is secured by collateral (including a right of setoff).
Brief Description of Collateral:
☐ Real Estate ☐ Motor Vehicle
☐ Other_____
Value of Collateral: $_____
Amount of arrearage and other charges at time case filed included in secured claim, if any: $_____

6. Unsecured Priority Claim.
☒ Check this box if you have an unsecured priority claim.
Amount entitled to priority $ 379.50
Specify the priority of the claim:
☐ Wages, salaries, or commissions (up to $4,650), earned within 90 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(3).
☐ Contributions to an employee benefit plan – 11 U.S.C. §507(a)(4).
☐ Up to $ 2,100 of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(6).
☐ Alimony, maintenance, or support owed to a spouse, former spouse, or child - 11 U.S.C. § 507(a)(7).
☐ Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8).
☐ Other – Specify applicable paragraph of 11 U.S.C. § 507(a)(__).

7. Credits: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim.
8. Supporting Documents: Attach copies of supporting documents, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, explain. If the documents are voluminous, attach a summary.
9. Date-Stamped Copy: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

This Space is for Court Use Only
CL 4887
4-12-02

Date: 04-08-02

Sign and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any):
Gerald Kendrick

Penalty for presenting fraudulent claim: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

Kmart Customer Incident Information

Store Stamp

Dear Kmart Customer,

We want you to have a positive experience every time you visit our store. If you have experienced an accident or loss of any kind while visiting us, please provide the information requested below. This information will help us meet our goal of continuous improvement in the operation of our store. It will also help us in contacting you to make sure we are providing the service you expect.

Please take the white copy of this document for your records. If after leaving the store you wish to provide further information or have any questions about your incident, please call our Store Team Manager.

We are sorry you had an unpleasant experience while our guest. We look forward to serving you better in the future.

Sincerely,

Your Kmart Store Management

Store Phone Number: (504)885-1365

TO BE COMPLETED BY CUSTOMER:

Customer name: GERALD KENDRICK Customer's Street Address: 1416 MEADOW ST

City: METAIRIE State: LA Zip: 70003-5921 Phone: 738-9067

Customer's employer: RETIRED Customer's sex: MALE

Customer's Date of Birth: 08-27-1938 Customer's Social Security Number: 437-58-8811

If injury to a child: Child's name: _____ Child's age: _____ Parent's name: _____

Customer's Description of Incident:

Date of incident: 09-29-2001 Location of incident: GARDEN CENTER

Time of incident: 10:00AM What happened? WHILE WALKING PAST GARDEN CENTER, THE GARDEN HOSE PIPE TRIPPED ME CAUSING ME TO FALL TO THE GROUND. MY ARM WAS SWOLLEN AFTER THE FALL.

Do you wish to be contacted? YES Date reported: 09-29-01 Signature of Customer: Gerald Kendrick

White copy - For Customer

code (37) 094-4699-115 Rev 2/01 25/PK

STORE AUTHORIZATION FOR FIRST AID

STORE STAMP

7229 Big Kmart
7000 VETERANS MEMORIAL
METAIRIE, LA 70003

To: _____
Name of Doctor, Clinic or Hospital

Authorized By: _____

We will pay the reasonable and ordinary charges for one time emergency first aid treatment of the patient described below, administered within 24 hours of the incident described below, if this form is completed in its entirety, including the Medical Report section below, and this completed form is returned to the store with an itemized bill and a copy of the admitting notes. This authorization is for first aid only, and does not extend to follow-up care and is not an admission of liability.

TO BE COMPLETED BY STORE PERSONNEL

Patient Name BERN KENDRICK Incident Date 09-29-01 Incident Time 10:00

Address 1416 Meadow ST DOB 03-2238 Soc. Sec. No. 437-58-8811

METAIRIE LA 70003 Height 5'4 Weight 145
(City) (State) (Zip Code)

Patient's Employer RETIRED

TO BE COMPLETED BY PATIENT

PATIENT AUTHORIZATION TO RELEASE INFORMATION

To: **Any and all providers of medical services:** This authorization or a copy of this authorization will allow you to give to the above-described store or its representative any information you have regarding my medical history, physical, clinical or laboratory findings, diagnosis, treatment, prognosis and related information.

Patient Signature Kendrick Date 09-29-2001
(Parent should sign for patient under age 18 and print child's name next to parent's signature.)

TO BE COMPLETED BY PHYSICIAN

PHYSICIAN'S MEDICAL REPORT

Date of examination / treatment _____

History of incident given by patient FELL ONTO RIGHT ARM 10 AM.

Patient's complaints RIGHT FOREARM PAIN

Clinical findings TENDER " " "

Has patient ever had same or similar condition NO If yes, when? _____

Diagnosis CONTUSED RIGHT ELBOW

Treatment rendered EXAM

Prognosis: Is patient disabled? NO If yes, how long is disability expected? 5 DAYS

Have you treated this patient before? NO Approximate date of last treatment NONE

Signature of physician [signature] FRANK M. WILSON, M.D. EMERGENCY MEDICINE Date 9/29/01

Name of physician _____ Fed ID _____

Office address EJGH 4200 Houma, Mgt. LA.

EJGH
East Jefferson General Hospital
4200 Houma Blvd., Metairie, LA 70011
504-454-4377

Kendrick Gerald
08/27/1938 Sep 29 2001 13:58 FT FTWR3
4532373 30061829050

Instructions for Care Followin

☐ **WOUND CARE**
Sutures out in _____ days.
1. Keep wound clean and dry for _____ hours.
2. Clean wound with soap and water, then peroxide and apply antibiotic ointment and cover with new bandage daily or as instructed.
3. Change the bandage if it gets wet or dirty.
4. Watch for signs of infection: swelling, redness, pus, drainage, red streaks, or increased pain.
5. Keep wound elevated to minimize swelling.

☐ Return for suture removal Monday-Friday, 3-6 p.m.

☐ Tetanus shot given
It is normal for the arm to be sore for several days.

☐ **URI / BRONCHITIS / PHARYNGITIS**
1. Take medications as directed.
2. Rest and fluids are helpful.
3. Call your doctor or return if you develop trouble breathing, high fever or shaking chills, blood in your sputum, increasing cough, or problems swallowing.

☑ **SPRAIN / STRAIN CONTUSION**
1. Rest the injured extremity and keep it elevated whenever possible.
2. Apply ice/cold pack 4 times daily for the first 1-2 days.
3. After the first 1-2 days, you may apply heat to the injury to help relieve pain.
4. If an elastic bandage is used, rewrap it if it becomes too loose or too tight.
5. Use crutches for walking, if indicated, for X days (non-weight bearing).
6. Call your doctor or return if you have increased pain, swelling, or numbness.

☐ **CAST / SPLINT CARE**
1. Keep extremity with cast/splint elevated with sling or on pillow.
2. Keep cast/splint clean and dry.
3. Never put objects in cast/splint.
4. Watch for swelling, numbness, or discoloration of fingers or toes. Call doctor if any occur.

☐ **EAR INFECTION**
1. Take medications as directed.
2. Call your doctor or return if the earache or fever is not better is 2 days, you get severe headache, increased swelling around your ear, feel dizzy, have a stiff neck or cannot walk normally, or notice increased fussiness or poor feeding in an infant.

DISCHARGE INSTRUCTIONS GIVEN:

☐ UTI ☐ Head Injury ☐ Neck Pain
☐ Fever ☐ Vomiting/Diarrhea
☐ Eye Injury ☐ Back Pain
☐ Other _____

SPECIAL INSTRUCTIONS: _____
RECHECK 4 - 5 DAYS
IF NOT WELL

MEDICATIONS PRESCRIBED: _____

Prescription received with instructions?
☐ Yes ☐ No

Treatment in the Emergency Department is offered a emergency care. Follow up treatment by a physicia is importnat to your health. You are urged to follo the instructions given on this sheet carefully. Retu to the Emergency Department if you have any prol lems you feel are getting worse or are concerned abou before seeing your doctor.

☐ Call Dr. _____ at _____ (PHONE)
for follow up care within _____ days.

_____ (ADDRESS)

☐ Call Health Finders (**456-5000**, Mon.-Fri., 8 a.m.-5 p.m.)
to make an appointment with _____ (SPECIALIST)
for follow up care within _____ days.

☐ Your x-rays have been read on a preliminary basis by the Emergency Physician. Final consultation and review by the radiologist will be made the following day. If there are any significant abnormalities, you will be contacted.

☐ **SCHOOL / WORK EXCUSE**
No school for _____ days
No physical education for _____ days
May return to school in _____ days
Light duty for _____ days
May return to work in _____ days

I, (patient or authorized person to consent), understand the recommendations and/or instructions given.

_____ (SIGNATURE) _____ (DATE)

_____ (GIVEN BY) _____ (R.N. / M.D.)

KMART STORE 7223

0003828	CEREAL	A	1.99 S
00000828	CEREAL	A	1.99 S
49003908	PEPTO BISMOL		2.94 T
551066	HAND TOWEL		
4 @ 1/2.00		A	8.00 T
**** TAX	1.26 BAL		16.18
Cash			20.00
CHANGE			3.82
TOTAL SAVINGS	3.40		

TOTAL NUMBER OF ITEMS SOLD = 7

RECEIPT# 07223 092901 012 65225

09/29/01 9:59 AM 7223 12 6522 0163

** GET SPECIAL DEALS VIA EMAIL!!! **
** REGISTER AT WWW.BLUELIGHT.COM **

Kendrick Gerald L
08/27/1938 Sep 29 2001 13:21 WAITING

KMART STORE 7223

03800000828	CEREAL	A	1.99 S
03800000828	CEREAL	A	1.99 S
30149003908	PEPTO BISMOL		2.94 T
07046551066	HAND TOWEL		
4 @ 1/2.00		A	8.00 T
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