

**CITY OF WINTERS
CLAIM FORM**

CLAIM AGAINST: _____
(For damages to persons or personal property)

DATE RECEIVED: (Stamp and Initial)

RECEIVED VIA:

U.S. Mail: _____
Over the counter _____

A claim must be filed within SIX (6) MONTHS after which the incident or event occurred. Be sure your claim is against the City of Winters and not another public entity. Where space is insufficient, please use additional paper and identify information by paragraph number. Completed claims must be mailed or delivered to (do not fax or email):

**City of Winters
City Clerk's Office
318 First St.
Winters, CA 95694**

The undersigned respectfully submits the following claim and information relative to damage to persons and/or personal property:

A. Claimant's Name: _____

Address: _____

City/State/Zip: _____

B. Address to which the claimant desires notices to be sent:

C. Date of the occurrence or transaction which gave rise to the claim asserted: _____

Place of occurrence: (Provide specific address if known and a description of the location.)

D. The name or names of the public employee(s) causing the injury, damage, or loss, if known

E. A general description of the indebtedness, obligation, injury, damage or loss incurred so far as it may be known at the time of presentation of claim. (Please be specific with your information and the actions leading up to the occurrence. Failure to provide a general report of the occurrence that allows the City to ascertain the events leading up to the indebtedness, obligation, injury, damage or loss may result in your claim being returned to you as initially denied due to incompleteness. Use additional paper as necessary.)

F. The amount claimed as of the date of presentation of the claim, including the estimated amount of any prospective injury, damage, or loss, insofar as it may be known at the time of presentation of the claim, together with the basis of computation of the amount claimed:

Damages claimed:

- 1. Amount claimed as of this date: \$ _____
- 2. Estimated amount of future costs: + _____
- 3. Total amount claimed: = _____

(Include copies of all bills, invoices, estimates, etc.)

G. Names and addresses of all witnesses, hospitals, doctors, etc.:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

H. Any additional information that might be helpful in considering claim: _____

WARNING:

IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM:
(penal code 72; insurance code 556.1)

I have read the matters and statements made in the above claim and I know the same to be true of my own knowledge, except as to those matters stated upon information or belief and as to such matters I believe the same to be true. I certify under penalty of perjury that the foregoing is TRUE and CORRECT.

Signed this _____ day of _____, of the year _____ at

(location)

CLAIMANT'S SIGNATURE