



**CLAIM FOR DAMAGES  
TO PERSON OR PROPERTY**

TO: (Entity) \_\_\_\_\_

1. Claims for death, injury to person or to personal property must be filled out not later than six months after the occurrence. (Gov. Code Sec. 911.2)
2. Claims for damages to real property must be filled not later than 1 year after the occurrence.
3. Read entire claim form, both sides, before filing.
4. See page 2 for diagram upon which to locate place of accident.
5. This claim form must be signed on page 2 at bottom.
6. Attach separate sheets, if necessary, to give full details. **SIGN EACH SHEET.**

NAME OF CLAIMANT	Date of Birth of Claimant
Home Address of Claimant	Occupation of Claimant
City and State	Home Telephone Number
Business Address of Claimant	Business Telephone Number
City and State	
Give address and telephone number to which you desire notices or communications to be sent regarding this claim:	
When did DAMAGE or INJURY occur? Date _____ Time _____  If claim is for Equitable Indemnity, give date claimant served with the complaint: Date _____	Section 111 of the Medicare Medicaid & S-CHIP Extension Act requires the entity to report certain claims to the federal government. Please indicate if the claimant is: 65 years of age or older, or is receiving Social Security Disability Insurance Benefits for 24 or more months, or has End Stage Renal Disease. If yes, you may be required to provide additional information to process your claim. <b>YES / NO</b> (circle one)

Where did DAMAGE or INJURY occur? Describe fully, and locate-on-diagram on Page 2. Where appropriate, give street names and address and measurements from landmarks.

Describe in detail how the DAMAGE or INJURY occurred:

Names of any employees involved in INJURY or DAMAGE:  
Why do you claim the Entity is responsible?

Describe in detail each INJURY or DAMAGE:

The amount claimed, as of the date of presentation of the claim, is computed as follows:

Damage to property.....\$ _____	Estimated prospective damages as far as known
Expenses for medical and hospital care...\$ _____	Future expenses for medical and hospital care.....\$ _____
Loss of earnings.....\$ _____	Future loss of earnings.....\$ _____
Special damages for.....\$ _____	Other prospective special damages.....\$ _____
	Total estimate prospective damages.....\$ _____

General Damages.....\$ \_\_\_\_\_  
 Total damages Incurred to date.....\$ \_\_\_\_\_

Total amount claimed as of date of presentation of the claim: \$ \_\_\_\_\_

Was damage and/or injury investigated by police? \_\_\_\_\_ If so, what city? \_\_\_\_\_  
 Were paramedics or ambulance called? \_\_\_\_\_ If so, name city or ambulance \_\_\_\_\_  
 If injured, state date, time, name and address of doctor of your first visit \_\_\_\_\_

WITNESSES to DAMAGE or INJURY. List all person and addresses of persons known to have information:

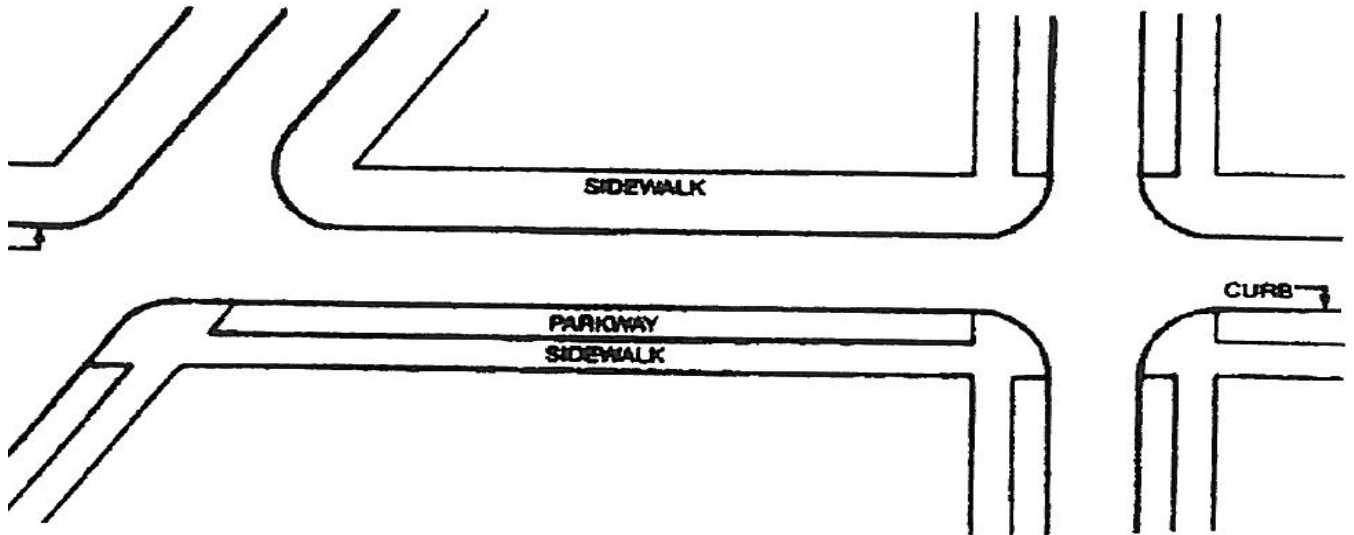
Name _____	Address _____	Phone _____
Name _____	Address _____	Phone _____
Name _____	Address _____	Phone _____

DOCTORS and HOSPITALS

Hospital _____	Address _____	Date Hospitalized _____
Doctor _____	Address _____	Date of Treatment _____
Doctor _____	Address _____	Date of Treatment _____

READ CAREFULLY

For all accident claims place on following diagram names of streets, including North, East, South and West. Indicate place of accident by "X" and by showing house numbers or distance to street corners.	NOTE: If diagrams below do not fit the situation, attach hereto a proper diagram signed by claimant.
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Signature of Claimant or person filing on his behalf giving relationship to Claimant:	PRINT Name:	Date:
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