



**INSTRUCTIONS:**

1. Read claim *thoroughly*.
2. Fill out claim as indicated; attach additional information if necessary.
3. This office needs the original completed claim form and clear readable copies of attachments (if any) if originals are not available.
4. This claim form *must* be signed.

OFFICE USE ONLY

**DELIVER OR U.S. MAIL TO:** CLERK OF THE BOARD OF SUPERVISORS  
 ATTN: CLAIMS DIVISION  
 P.O. BOX 1147, 4080 LEMON ST, 1<sup>ST</sup> FL.  
 RIVERSIDE, CA. 92502-1147 (951) 955-1060

TIME STAMP HERE

1. FULL NAME OF CLAIMANT		8. WHY DO YOU CLAIM THE COUNTY IS RESPONSIBLE?	
2. MAILING ADDRESS (STREET / PO BOX)			
CITY		STATE	ZIP CODE
HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )		9. NAMES OF ANY COUNTY EMPLOYEES (AND THEIR DEPARTMENTS) INVOLVED IN INJURY OR DAMAGE (IF APPLICABLE).
3. WHEN DID DAMAGE OR INJURY OCCUR (PLEASE BE EXACT)		NAME:	DEPARTMENT:
4. WHERE DID DAMAGE OR INJURY OCCUR?		10. WITNESSES TO DAMAGE OR INJURY: LIST ALL PERSONS AND ADDRESSES OF PERSONS KNOWN TO HAVE INFORMATION:	
STREET	CITY	STATE	ZIP CODE
5. DESCRIBE IN DETAIL HOW DAMAGE OR INJURY OCCURRED:		NAME	
		PHONE	
		ADDRESS	
		NAME	
		PHONE	
		ADDRESS	
		NAME	
		PHONE	
		ADDRESS	
		ADDRESS	
6. WERE POLICE OR PARAMEDICS CALLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. LIST DAMAGES INCURRED TO DATE (attach copies of receipts or repair estimates)	
7. IF PHYSICIAN/HOSPITAL WAS VISITED DUE TO INJURY, INCLUDE DATE OF FIRST VISIT AND HOSPITAL'S NAME, ADDRESS AND PHONE NUMBER:			
DATE OF FIRST VISIT		PHYSICIAN'S/HOSPITAL'S NAME	
PHYSICIAN'S/HOSPITAL'S ADDRESS		PHONE:	
( )		<u>TOTAL DAMAGES TO DATE</u> <u>TOTAL ESTIMATED PROSPECTIVE DAMAGES</u> \$ _____      \$ _____	

**THIS CLAIM MUST BE SIGNED TO BE VALID.      NOTE: PRESENTATION OF A FALSE CLAIM IS A FELONY (PENAL CODE SECTION 72.)**

**WARNING :**

- CLAIMS FOR DEATH, INJURY TO PERSON OR TO PERSONAL PROPERTY MUST BE FILED NOT LATER THAN SIX (6) MONTHS AFTER THE OCCURRENCE. (GOVERNMENT CODE SECTION 911.2)
- ALL OTHER CLAIMS FOR DAMAGES MUST BE FILED NOT LATER THAN ONE (1) YEAR AFTER THE OCCURRENCE. (GOVERNMENT CODE SECTION 911.2)
- SUBJECT TO CERTAIN EXCEPTIONS. YOU HAVE ONLY SIX (6) MONTHS FROM THE DATE OF THE WRITTEN NOTICE OF REJECTION OF YOUR CLAIM TO FILE A COURT ACTION. (GOVERNMENT CODE SECTION 945.6)
- IF WRITTEN NOTICE OF REJECTION OF YOUR CLAIM IS NOT GIVEN, YOU HAVE TWO (2) YEARS FROM ACCRUAL OF THE CAUSE OF ACTION TO FILE A COURT ACTION. (GOVERNMENT CODE SECTION 945.6)

12. CLAIMANT OR PERSON FILING ON HIS/HER BEHALF	13. PRINT OR TYPE NAME
SIGNATURE	RELATIONSHIP TO CLAIMANT