

CLAIM FOR DAMAGES TO PERSON OR PROPERTY

File With: City of San Fernando, Administration Department – Personnel Division, 117 Macneil Street, San Fernando, CA 91340

1. Claims for death, injury to person or to personal property must be filed no later than six months after the occurrence (Gov. Code §911.2).
2. Claims for damages to real property must be filed no later than one year after the occurrence (Gov. Code §911.2).
3. Read entire claim form 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.

TO: CITY OF SAN FERNANDO

CLAIMANT INFORMATION

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
HOME ADDRESS	HOME TELEPHONE NUMBER	
BUSINESS ADDRESS	BUSINESS TELEPHONE NUMBER	
GIVE ADDRESS AND TELEPHONE NUMBER TO WHICH YOU DESIRE NOTICES OR COMMUNICATIONS TO BE SENT REGARDING THIS CLAIM	OCCUPATION	

DAMAGE OR INJURY INFORMATION

WHEN AND WHERE DID DAMAGE OR INJURY OCCUR?		NAME OF ANY CITY EMPLOYEES INVOLVED IN INJURY OR DAMAGE
DATE	TIME	
ADDRESS		
IF CLAIM IS FOR EQUITABLE INDEMNITY, GIVE CLAIMANT SERVED WITH COMPLAINT		DATE

DESCRIBE IN DETAIL HOW THE DAMAGE OR INJURY OCCURRED

WHY DO YOU CLAIM THE CITY RESPONSIBLE?

DESCRIBE IN DETAIL EACH DAMAGE OR INJURY

CLAIM FOR DAMAGES TO PERSON OR PROPERTY

THE AMOUNT CLAIMED, AS OF THE DATE OF PRESENTATION OF THIS CLAIM, IS COMPUTED AS FOLLOWS:

Damages incurred to date (exact):		Estimated prospective damages as far as known:	
Damage to property	\$ _____	Future expenses for medical & hospital care	\$ _____
Expenses for medical & hospital care	\$ _____	Future loss of earnings	\$ _____
Loss of earnings	\$ _____	Other prospective special damages	\$ _____
Special damages for _____	\$ _____	Prospective general damages	\$ _____
General damages	\$ _____		
TOTAL DAMAGES INCURRED TO DATE	\$ _____	TOTAL ESTIMATE OF PROSPECTIVE DAMAGES	\$ _____

TOTAL AMOUNT CLAIMED AS OF THE DATE OF THIS PRESENTATION \$ _____

Was damage and/or injury investigated by police? Yes No If so, what city? _____

Were paramedics or ambulance called? Yes No 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 persons and addresses of persons known to have information*

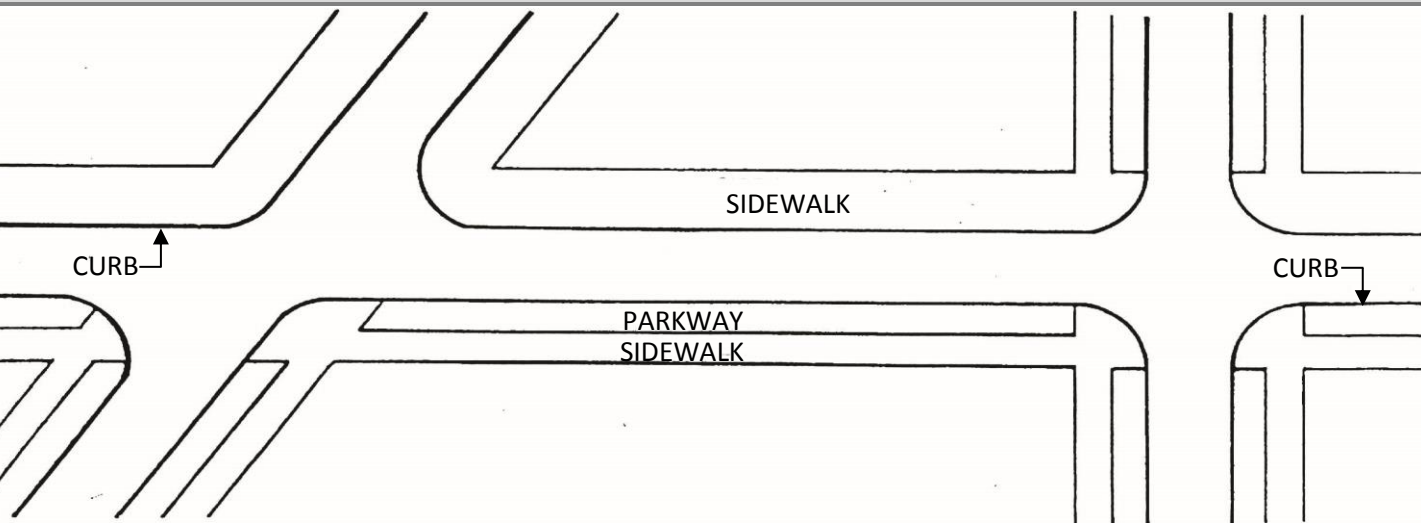
NAME	ADDRESS	PHONE
NAME	ADDRESS	PHONE
NAME	ADDRESS	PHONE

DOCTORS AND HOSPITALS

HOSPITAL	ADDRESS	PHONE
HOSPITAL	ADDRESS	PHONE
HOSPITAL	ADDRESS	PHONE

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 distances to street corners. If City vehicle was involved, designate by letter "A" location of City vehicle when you first saw it, and by "B" location of yourself or your vehicle when you first saw City vehicle at time of accident by "A-1" and location of yourself or your vehicle at the accident by "B-1" and the point of impact by "X". NOTE: If diagrams below do not fit the situation, attach hereto a proper diagram signed by claimant.



SIGNATURE OF CLAIMANT OR PERSON FILING ON BEHALF OF CLAIMANT (PLEASE STATE RELATIONSHIP): _____

TYPED NAME	DATE
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NOTE: PRESENTATION OF A FALSE CLAIM IS A FELONY (PENAL CODE §72)