CLAIMS FOR DAMAGES AGAINST THE COUNTY OF IMPERIAL

FOR CLERK OF THE BOARD USE ONLY

Received by:
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DO NOT WRITE IN THIS SPACE
FOR CLERK OF THE BOARD USE ONLY

CLAIM # ______________________
14 DAYS ______________________
45 DAYS ______________________

A CLAIM MUST BE FILED WITH THE COUNTY OF IMPERIAL CLERK OF THE BOARD OF SUPERVISORS WITHIN 6 MONTHS AFTER THE INCIDENT OR EVENT OCCURRED. BE SURE YOUR CLAIM IS AGAINST THE COUNTY OF IMPERIAL, NOT ANOTHER PUBLIC ENTITY. WHERE SPACE IS INSUFFICIENT, PLEASE USE ADDITIONAL PAPER**. ALL CLAIMS MUST BE RETURNED TO COUNTY OF IMPERIAL ATTN: BLANCA ACOSTA, CLERK OF THE BOARD OF SUPERVISORS, 940 MAIN STREET, SUITE 209, EL CENTRO, CA. 92243.**

Name of Claimant: ____
Last First Middle

Address of Claimant: ____
Street Address/PO Box City State Zip

Home Phone :(   ) ____________________ **Work Phone :(   )** ____________________

Date of Birth:________________________

Name and address to which claimant desires notice to be sent if different from above:

____
Name Street Address/PO Box City State Zip

Date damage/injury occurred: __________________ **Time damage/injury occurred:**______________

Location injury/damage occurred: ____

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Specify the particular occurrence, event, act or omission you claim caused the injury or damage (use additional paper if necessary): ____

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Describe how the County of Imperial or its employees were at fault. Give the name(s) of the County department and employee(s) causing the damage or injury:______________________________

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Give a description of the injury, property damage, or loss, so far as is known at the time of the claim. If there were no injuries, please state "NO INJURIES":______________________________

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

1. ____
Name Address City State Zip Phone No.
2. ____
Name Address City State Zip Phone No.
3. ____
Name Address City State Zip Phone No.

CONTINUED ON OTHER SIDE

REVISED 12/06

Damages Claimed:

- *Amount Claimed as of this date:* $__________________________
- *Estimated amount of future costs:* $__________________________
- ***Total Amount Claimed**:* $__________________________

Basis for computation of amounts claimed (Please attach copies of all bills, invoices, estimates, etc):

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Damaged vehicle if applicable: Make:_____________ Model:_____________ Year:________

VIN No.: ______________________________________ Mileage: _________________________________

Insurance Company:____ Policy No:__________________

Is vehicle a company vehicle, if so give name and address of company: ________________________________

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Any additional information that might be helpful in considering this claim: ____________________________

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1. Please read claim thoroughly and complete claim form as indicated. Attach additional information if necessary.
2. Claim form **MUST be signed** by claimant or on behalf of the claimant.
3. Completed claims must be mailed or returned to:

   County of Imperial
   Attn: Blanca Acosta
   Clerk of the Board of Supervisors
   940 West Main Street, Suite 209
   El Centro, CA. 92243

WARNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM (Penal Code Section 72).

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.

Claimant's Signature ►	Print or type name	Date

DATE STAMP