

**CLAIMS FOR DAMAGES AGAINST
THE COUNTY OF IMPERIAL**

FOR CLERK OF THE BOARD USE ONLY

Received by:

U.S. Mail

Interoffice mail

Over the Counter



**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: CYNTHIA MEDINA, 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: _____

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

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: _____

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": _____

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):

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: _____

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

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: Cynthia Medina
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