

**CLAIM AGAINST THE
CITY OF WEST SACRAMENTO
FOR DAMAGES TO PERSON OR PROPERTY**

Instructions:

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 (land/structures) 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 3 at bottom.
6. Attach separate sheets, if necessary, to give full details. SIGN EACH SHEET.

NAME OF CLAIMANT (First Middle Last)		Date of Birth of Claimant
Home Address of Claimant		Occupation of Claimant
City and State		Home Telephone Number
Business Address of Claimant		()
City and State		Business Telephone Number
		()
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. YES / NO <div style="text-align: right;">(circle one)</div>	

Where did DAMAGE or INJURY occur? Describe fully, and locate on diagram on Page 3.
(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:

Damages incurred to date (exact)

Estimated prospective damages as far as known

Damage to property..... \$ _____

Future expenses for medical and hospital care..... \$ _____

Expenses for medical and hospital care...\$ _____

Future loss of earnings..... \$ _____

Loss of earnings.....\$ _____

Other prospective special damages..... \$ _____

Special damages for.....\$ _____

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, do you have a report number? _____

Were paramedics or ambulance called? _____ If so, name agency 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 _____

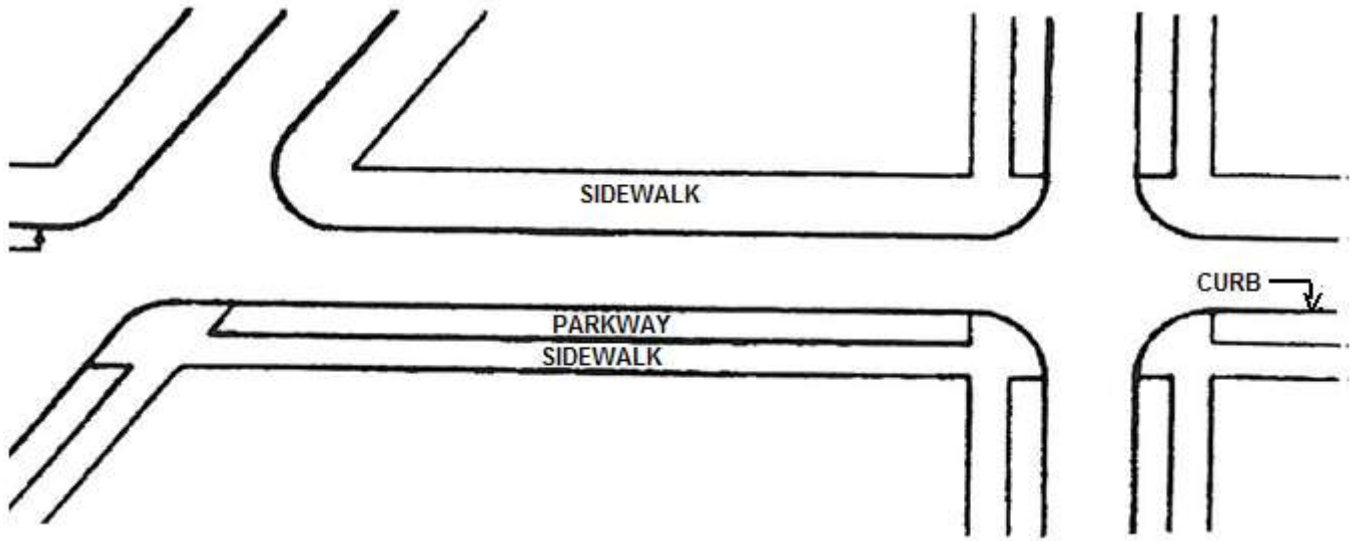
Doctor _____ **Address** _____

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.



Signature of Claimant: <i>(or person filing on his/her behalf and relationship to Claimant)</i>	PRINT Name:	Date:
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NOTE: CLAIMS MUST BE FILED WITH THE CLERK OR GOVERNING BOARD (Gov. Code Sec. 915a). Presentation of a false claim is a felony (Pen. Code Sec. 72)

Completed claims must be either mailed or hand-delivered to:

CITY OF WEST SACRAMENTO
1110 West Capitol Ave.
West Sacramento, CA 95691
(916) 617-4500

Date Received by the City of West Sacramento
