



**LIABILITY CLAIM
FOR DAMAGES
TO PERSON OR PROPERTY**

CITY CLERK DATE STAMP

RETURN TO:

CITY OF YUCAIPA
OFFICE OF THE CITY CLERK
34272 YUCAIPA BLVD.
YUCAIPA, CA 92399

DISTRIBUTION:

- CITY MANAGER
- CITY ATTORNEY
- FINANCE DEPT (Original/1)
- INSURANCE ADJUSTER
- DEPARTMENT: _____
- CITY CLERK'S LOG

1. Claims for death, injury to person, or to personal property must be filed not later than six (6) months after the occurrence (Gov. Code Sec. 911.2).
2. Claims for damages to real property must be filed not later than one (1) year after the occurrence (Gov. Code Sec. 911.2).
3. READ ENTIRE CLAIM FORM BEFORE FILING.
4. ATTACH SEPARATE SHEETS, IF NECESSARY, TO GIVE FULL DETAILS.

NAME OF CLAIMANT

DATE OF BIRTH OF CLAIMANT

HOME ADDRESS OF CLAIMANT CITY/STATE/ZIP

()

HOME TELEPHONE NO.

BUSINESS ADDRESS OF CLAIMANT CITY/STATE/ZIP

()

BUSINESS TELEPHONE NO.

ADDRESS TO WHICH CLAIMANT DESIRES NOTICES OR COMMUNICATIONS SENT REGARDING THIS CLAIM (if different from home address):

WHEN DID DAMAGE OR INJURY OCCUR?

DATE: _____

TIME: _____ A.M. P.M.

PLACE OF ACCIDENT (OCCURRENCE)-**BE SPECIFIC**- Describe fully and (if applicable) locate on diagram contained on sheet #3. Where appropriate, give street names and addresses and measurements for landmarks.

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HOW DID DAMAGE OR INJURY OCCUR?

WERE POLICE AT SCENE? YES NO WERE PARAMEDICS AT SCENE? YES NO

WHAT PARTICULAR **ACT** OR **OMISSION** DO YOU CLAIM CAUSED THE INJURY OR DAMAGES? (Give name of City employee causing the injury or damage, if known.)

GIVE TOTAL AMOUNT OF CLAIM: (Include estimate of amount of any prospective injury or damage)\$_____

HOW WAS THE AMOUNT OF CLAIM COMPUTED? (Be specific, list doctor bills, repair estimates, etc.)
PLEASE ATTACH TWO (2) ESTIMATES.

DAMAGES INCURRED TO DATE:

ITEM/DATE _____	AMOUNT: \$ _____

PLEASE ATTACH TWO (2) ESTIMATES.

ESTIMATED PROSPECTIVE DAMAGES AS FAR AS KNOWN:

ITEM/DATE _____	AMOUNT: \$ _____

TOTAL ESTIMATED PROSPECTIVE DAMAGES:

WITNESSES TO DAMAGE OR INJURY: (List all persons known to have information. (Use attachment if necessary.)

NAME: _____	NAME: _____
ADDRESS: _____	ADDRESS: _____
TELEPHONE: () _____	TELEPHONE: () _____

IF INJURED, GIVE NAME, ADDRESS, TELEPHONE, DATE & TIME OF DOCTOR(S) OR HOSPITAL(S) VISITED:

DOCTOR: _____	TELEPHONE: _____
ADDRESS: _____	DATE/TIME: _____
HOSPITAL: _____	TELEPHONE: _____
ADDRESS: _____	DATE/TIME: _____

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PLEASE READ THE FOLLOWING CAREFULLY:

For all vehicle accident claims, place on following diagram, the names of streets, including NORTH, EAST, SOUTH AND WEST directions. Indicate place of accident by "X" and by showing house numbers or distances to street corners.

If a City vehicle was involved, designate by letter "A" location of the City vehicle when you first saw it, and by "B" location of yourself or your vehicle when you first saw City vehicle; location of City vehicle at time of accident by "A-1" and location of yourself or your vehicle at the time of the accident by "B-1" and the point of impact by "X".

NOTE: IF A DIAGRAM BELOW DOES NOT FIT THE SITUATION, ATTACH A PROPER DIAGRAM SIGNED BY CLAIMANT.

I HAVE READ THE FOREGOING CLAIM AND KNOW THE CONTENTS THEREOF; AND CERTIFY THAT THE SAME IS TRUE OF MY OWN KNOWLEDGE EXCEPT AS TO THOSE MATTERS, WHICH ARE HEREIN STATED UPON MY INFORMATION AND BELIEF; AND AS TO THOSE MATTERS I BELIEVE THEM TO BE TRUE.

I CERTIFY (OR DECLARE) UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

SIGNATURE OF CLAIMANT OR AGENT
ACTING ON BEHALF OF CLAIMANT

TYPE OR PRINT NAME

DATE

RELATIONSHIP TO CLAIMANT

NOTE: PRESENTATION OF A FALSE CLAIM IS A FELONY (CALIFORNIA PENAL CODE 72)