CITY OF DELANO

CENTRAL SAN JOAQUIN VALLEY
RISK MANAGEMENT AUTHORITY

CLAIM FORM

FORM B

(Please Type Or Print)

CLAIM AGAINST _____
(Name of Entity)

Claimant's name: _____

SS#: _____ DOB: _____ Gender: Male _____ Female _____

Claimant's address: _____

Claimant's Phone: _____

Address where notices about claim are to be sent, if different from above: _____

_____

Date of incident/accident: _____

Date injuries, damages, or losses were discovered: _____

Location of incident/accident: _____

What did entity or employee do to cause this loss, damage, or injury? _____

_____
(Use back of this form or separate sheet if necessary to answer this question in detail.)

What are the names of the entity's employees who caused this injury, damage, or loss (if known)? _____

_____

What specific injuries, damages, or losses did claimant receive? _____

_____
(Use back of this form or separate sheet if necessary to answer this question in detail.)

What amount of money is claimant seeking or, if the amount is in excess of $10,000, which is the appropriate court of jurisdiction. Note: If Superior and Municipal Courts are consolidated, you must represent whether it is a "limited civil case" [see Government Code 910(f)] _____

_____

How was this amount calculated (please itemize)? _____

_____

(Use back of this form or separate sheet if necessary to answer this question in detail.)

Date Signed: _____ Signature: _____

If signed by representative:

Representative's Name _____ Address _____

Telephone # _____

Relationship to Claimant _____