FILE COMPLETED FORM BY MAIL OR IN PERSON AT:

CITY OF FULLERTON
City Clerk's Office
303 W. Commonwealth Avenue
Fullerton, CA 92832

OFFICE USE ONLY
RESERVE FOR FILING STAMP

CLAIM FOR DAMAGES

TO PERSON OR PROPERTY

CLAIM NO. _____

INSTRUCTIONS

1. Claim for death, injury to person or to personal property must be filed no later than six months after the occurrence (Gov. Code Sec. 911.2).
2. Claims for damages to real property must be filed no later than 1 year after the occurrence (Gov. Code Sec. 911.2).
3. Read entire claim form before filing.
4. See page 2 for diagram upon which to depict location of accident.
5. **THIS CLAIM FORM MUST BE SIGNED AND DATED ON PAGE 2 AT BOTTOM**.
6. Attach separate sheets, if necessary, to give full details. SIGN EACH SHEET.

TO: CITY OF FULLERTON	Date of Birth of Claimant
Name of Claimant	Occupation of Claimant
Home Address of Claimant City, State & Zip	Home Telephone Number ( )
Business Address of Claimant City, State & Zip	Business Telephone Number ( )
If different from above state name, address and telephone number to which you desire notices or communications to be sent regarding this claim:	Cellular Telephone Number ( )

When did DAMAGE or INJURY occur? Date_____ Time _____ A.M. or P.M. If claim is for Equitable Indemnity, give date claimant served with the complaint: Date_____	Names of any city employees involved in INJURY or DAMAGE

Where did DAMAGE or INJURY occur? Describe fully, and depict on diagram on reverse side of this sheet. Where appropriate, give street names and address and distances from landmarks:

Describe in detail how the DAMAGE or INJURY occurred:

Why do you claim the City is responsible?

Describe in detail each INJURY or DAMAGE:

THIS CLAIM MUST BE SIGNED ON REVERSE SIDE

CC to Claimant _____

The amount claimed, as of the date of presentation of this claim, is computed as follows:

Damages incurred to date (exact):	Estimated prospective damages as far as known:
Damage to property.....$_____	Future expenses for medical/hospital care...$_____
Expenses for medical/hospital care.....$_____	Future loss of earnings.....$_____
Loss of earnings .....$_____	Other prospective damages (detail) .....$_____
Total damages incurred to date.....$_____	Total estimated prospective damages.....$_____

TOTAL AMOUNT CLAIMED AS OF DATE OF PRESENTATION OF THIS CLAIM ...$_____

Was damage and/or injury investigated by police? _____ If so, what city?_____ Case No. _____
Were paramedics or an ambulance called? _____ If so, name city or ambulance _____
If injured, state date, time, name and address of doctor for your first visit:

WITNESSES to DAMAGE or INJURY. List all persons and addresses of persons known to have information.

Name _____ Address _____ Phone ( ) _____
Name _____ Address _____ Phone ( ) _____
Name _____ Address _____ Phone ( ) _____

DOCTORS and HOSPITAL:

Hospital _____ Address _____ Date Hospitalized _____
Doctor _____ Address _____ Date of Treatment _____
Doctor _____ Address _____ Date of Treatment _____

READ CAREFULLY

For all accident claims place on the following diagram names of streets, including North, South, East and West. Indicate place of accident by “X” and by showing house numbers or distances to street corners. If city vehicle was involved, designate by letter “A” location of City vehicle when you first saw it, and by “B” location of yourself or your vehicle when you first saw City vehicle. Indicate place 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 the diagram below does not fit the situation, attach a proper diagram signed by claimant.

Signature of Claimant or person filing on behalf of Claimant (give relationship to Claimant):	Type or Print Name:	Date:

NOTE: CLAIMS MUST BE FILED IN THE CITY CLERK’S OFFICE (Gov. Code Sec. 915.A) PRESENTATION OF A FALSE CLAIM IS A FELONY (Pen. Code Sec. 72).

CC to Claimant _____