

CLAIM FOR DAMAGES FORM

DIRECTIONS: Complete and send an original and one copy to: \_\_\_\_\_
(Insert District Name, Contact and Address).

Name of Claimant: \_\_\_\_\_
(Injured or damaged party) (Last) (First) (Middle)

Home Address: \_\_\_\_\_
(Date of Birth) \* (Social Security No.)\* (CA Drivers License No.)
(Number/Street) (City/State/Zip Code) (Area Code & Phone No.)

Business Address: \_\_\_\_\_
(Number/Street) (City/State/Zip Code) (Area Code & Phone No.)

Claimant receives or is eligible for SSDI or Medicare\* " " Yes " " No

Directions: Indicate to which address you wish notices sent. " " Home " " Business"

When Did Injury or Damage occur? \_\_\_\_\_
(Month/Day/Year) (Day of Week) (Time of Day)

Where Did Injury or Damage Occur? \_\_\_\_\_
(School site, street address, intersecting streets, or other locations)

How Did Injury or Damage Occur? \_\_\_\_\_
(Describe accident or occurrence in complete detail/attach additional pages if needed)

Names, Addresses and Phone Numbers of Witnesses, Doctors, Hospitals or persons who may have information regarding Your Injury or Damages: \_\_\_\_\_

Names of School Employees Involved: \_\_\_\_\_

Police Report Number: \_\_\_\_\_

What Action or Inaction of District Employee(s) Caused Your Injury or Damages? \_\_\_\_\_

What Injuries or Damages Did You Suffer? \_\_\_\_\_

State the amount of the claim if it is less than \$10,000 \_\_\_\_\_.

Include the estimated amount of any prospective injury, damage or loss insofar as it may be known at the time the claim is presented and list the basis for the computation of the amount claimed:

If the dollar amount of the claim is more than \$10,000, no dollar amount will be stated but please indicate whether the claim is a limited civil claim(total dollar amount less than \$25,000): Limited Civil Case: " " Yes " " No

Directions: Sign and date this Form below. If the signer is not the Claimant, indicate the relationship of the signer to the Claimant (parent, attorney etc.) and address.

(Signature) (Date) (Relationship if not Claimant and address)

Directions: Attach and include, with this Form, any bills for medical treatment or expenses/estimates for personal property damage.

\*RESPONSES REQUIRED FOR FEDERAL MEDICARE SECONDARY PAYER REPORTING
Note: PRESENTATION OF A FALSE CLAIM IS A FELONY (Refer to CA Penal Code Sec 72)