COUNTY OF RIVERSIDE CLAIM FOR DAMAGES TO PERSON OR PROPERTY

INSTRUCTIONS:

1. Read claim *thoroughly*.
2. Fill out claim as indicated; attach additional information if necessary.
3. This office needs the *original* completed claim form and clear readable copies of attachments (if any) if originals are not available.
4. This claim form *must* be signed.

DELIVER OR U.S. MAIL TO: CLERK OF THE BOARD OF SUPERVISORS
ATTN: CLAIMS DIVISION
P.O. BOX 1147, 4080 LEMON ST, 1ST FL.
RIVERSIDE, CA. 92502-1147 (951) 955-1060

OFFICE USE ONLY

TIME STAMP HERE

1. FULL NAME OF CLAIMANT	8. WHY DO YOU CLAIM THE COUNTY IS RESPONSIBLE?
2. MAILING ADDRESS (STREET / PO BOX)	
CITY STATE ZIP CODE	
HOME TELEPHONE ( ) / BUSINESS TELEPHONE ( )	9. NAMES OF ANY COUNTY EMPLOYEES (AND THEIR DEPARTMENTS) INVOLVED IN INJURY OR DAMAGE (IF APPLICABLE).
3. WHEN DID DAMAGE OR INJURY OCCUR (PLEASE BE EXACT)	NAME: / DEPARTMENT:
4. WHERE DID DAMAGE OR INJURY OCCUR?	10. WITNESSESS TO DAMAGE OR INJURY: LIST ALL PERSONS AND ADDRESSES OF PERSONS KNOWN TO HAVE INFORMATION:
STREET CITY STATE ZIP CODE	NAME / **PHONE**
5. DESCRIBE IN DETAIL HOW DAMAGE OR INJURY OCCURRED:	ADDRESS
	NAME / **PHONE**
	ADDRESS
	NAME / **PHONE**
	ADDRESS
	11. LIST DAMAGES INCURRED TO DATE (attach copies of receipts or repair estimates)
6. WERE POLICE OR PARAMEDICS CALLED? ☐ YES ☐ NO	
7. IF PHYSICIAN/HOSPITAL WAS VISITED DUE TO INJURY, INCLUDE DATE OF FIRST VISIT AND HOSPITAL'S NAME, ADDRESS AND PHONE NUMBER:	
DATE OF FIRST VISIT / PHYSICIAN'S/HOSPITAL'S NAME	
PHYSICIAN'S/HOSPITAL'S ADDRESS / PHONE: ( )	TOTAL DAMAGES TO DATE $_____ / TOTAL ESTIMATED PROSPECTIVE DAMAGES $_____

THIS CLAIM MUST BE SIGNED TO BE VALID. ***NOTE: PRESENTATION OF A FALSE CLAIM IS A FELONY (PENAL CODE SECTION 72.)***

W A R N I N G :

- CLAIMS FOR DEATH, INJURY TO PERSON OR TO PERSONAL PROPERTY MUST BE FILED NOT LATER THAN SIX (6) MONTHS AFTER THE OCCURRENCE. (GOVERNMENT CODE SECTION 911.2)
- ALL OTHER CLAIMS FOR DAMAGES MUST BE FILED NOT LATER THAN ONE (1) YEAR AFTER THE OCCURRENCE. (GOVERNMENT CODE SECTION 911.2)
- SUBJECT TO CERTAIN EXCEPTIONS. YOU HAVE ONLY SIX (6) MONTHS FROM THE DATE OF THE WRITTEN NOTICE OF REJECTION OF YOUR CLAIM TO FILE A COURT ACTION. (GOVERNMENT CODE SECTION 945.6)
- IF WRITTEN NOTICE OF REJECTION OF YOUR CLAIM IS NOT GIVEN, YOU HAVE TWO (2) YEARS FROM ACCRUAL OF THE CAUSE OF ACTION TO FILE A COURT ACTION. (GOVERNMENT CODE SECTION 945.6)

12. CLAIMANT OR PERSON FILING ON HIS/HER BEHALF	13. PRINT OR TYPE NAME DATE
SIGNATURE RELATIONSHIP TO CLAIMANT	