



CITY OF INDUSTRY
P.O. Box 3366, City of Industry, CA 91744
Administrative Offices: 15625 Mayor Dave Way
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LIABILITY
PUBLIC ENTITY CLAIM REPORTING FORM
FOR ALL PERSONS OR PROPERTY

DEPT. _____
CLAIM# _____
DATE FILED _____

PUBLIC ENTITY: _____
ATTENTION: _____
ADDRESS: _____

COPIES TO:

1. CLAIMS FOR DEATH INJURY TO PERSON, OR TO PERSONAL PROPERTY, MUST BE FILED NOT LATER THAN SIX MONTHS AFTER THE OCCURRENCE (GOV. CODE, SEC. 911.2).
2. CLAIMS FOR DAMAGES TO REAL PROPERTY MUST BE FILED NOT LATER THAN 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: _____ AGE: _____

HOME ADDRESS OF CLAIMANT (STREET, CITY AND STATE) _____
TELEPHONE NUMBER: _____

BUSINESS ADDRESS OF CLAIMANT (STREET, CITY AND STATE) _____
TELEPHONE NUMBER: _____

GIVE ADDRESS TO WHICH YOU DESIRE NOTICES OR COMMUNICATIONS TO BE SENT REGARDING THIS CLAIM:

DATE OF ACCIDENT: _____ TIME: _____ A.M. _____ P.M.

PLACE OF ACCIDENT (BE SPECIFIC) _____

HOW DID DAMAGE OR INJURY OCCUR? (BE SPECIFIC) _____

WERE POLICE AT SCENE? YES _____ NO _____

NAME OF PUBLIC ENTITY'S EMPLOYEE CAUSING THE INJURY OR DAMAGE, IF KNOWN _____

GIVE TOTAL AMOUNT OF CLAIM (INCLUDE ESTIMATE AMOUNT OF ANY PROSPECTIVE *INJURY* OR DAMAGE.

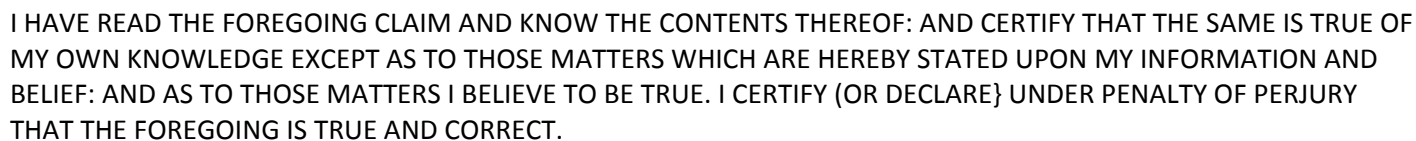
HOW WAS AMOUNT OF CLAIM COMPUTED? (BESPECIFIC. LIST DOCTOR BILL, WAGE RATE, REPAIR ESTIMATES, ETC.). PLEASE ATTACH TWO ESTIMATES: _____

THIS CLAIM MUST BE SIGNED ON REVERSE SIDE

NAME AND ADDRESS OF WITNESSES, DOCTORS AND HOSPITALS: _____

For all accident claims, place on following diagram names of streets, Including North, East, South and West; Indicate place of accident by "X" and by showing house numbers or distances to street corners.

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



Note: Presentation of a false claim is a felony (CAL. PEN. CODE 72).