



BEAR VALLEY COMMUNITY SERVICES DISTRICT CLAIMS FORM

Claimant's name: _____

Claimant's address: _____

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

Claimant's telephone no. _____ Email Address: _____

Date and time of accident/incident/transaction: _____

Location of accident/incident/transaction: _____

Brief description of the accident/incident/transaction: _____

Describe the specific injuries, damages, or losses: _____

Describe what the District or its employee(s) did to cause this loss, damage, or injury: _____

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

The amount of money claimant is seeking or, if the amount is in excess of \$10,000, whether the claim would be a limited-civil (where claim cannot exceed \$25,000): _____

Basis for calculating or itemizing any claimed amount. _____

The contact information (names, addresses, telephone, and email) for persons who witnessed the information provided above.

Treatment received, including the names and contact information of the hospital and doctors that provided the treatment.

Insurance policies for this claim, including automotive or liability insurance. Please include the name of insurance company, a description of the policy, and the policy number.

CRIMINAL PENALTY FOR PRESENTING A FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS. Every person who, with intent to defraud, presents any claim or writing to the District for payment may be subject to imprisonment and a fine. (See Penal Code § 72.)

PUBLIC RECORDS ACT. Information submitted on this form may be considered a public record, and may be subject to disclosure in response to a public records request.

ADDITIONAL INFORMATION. If you need more space for additional information, please include such information as an attachment to this form.

DECLARATION. By signing below, you declare under penalty of perjury that the foregoing is true and correct.

Date Signed: _____ Signature: _____

If signed by representative:

Representative's Name _____

Address _____

Telephone No. _____ Email _____

Relationship to claimant _____