CLAIM AGAINST COUNTY OF SAN BERNARDINO

(CLAIM FORM MUST BE FILLED OUT PROPERLY OR CLAIM WILL BE RETURNED WITHOUT FILING)

DATE: _____

Claim is hereby made against the treasury of the County of San Bernardino, State of California, as follows:

- Less than $10,000 – State the total amount claimed $ _____
- More than $10,000 – Check one of the boxes:

☐ Municipal Court Jurisdiction ($10,000 - $25,000) ☐ Superior Court Jurisdiction ($25,001 and up)

Claimant makes the following statements in support of the claim:

1. Name of Claimant: _____
   First Middle Last (Area Code and Phone No.)

2. Address of Claimant: _____
   Street City Zip Code

   Gender: ___ Male ___ Female Date of Birth:_____ SS#:_____
   (The information Requested is Mandatory if Presenting a Claim for Bodily Injury)

3. Notices concerning claim should be sent to:

   _____
   Name Address Zip Code (Area Code and Phone No.)

4. Circumstances giving rise to claim are as follows:_____

   _____

   _____

   _____

   _____

5. Date, Time and Place (city, street, cross-street) damage occurred and nature thereof:_____

   _____

   _____

6. Public property and/or public officers or employees causing injury, damage or loss:

   _____

   _____

7. Name, address and telephone number of witnesses:_____

   _____

8. Basis of computation of claimed amount is as follows:

   Medical expenses to date _____
   Estimated future medical expenses _____
   Other expenses _____
   Other damages _____

   Loss wages _____
   General damages _____
   Property damage _____

_____
Claimant or Representative (Signature)

RETURN COMPLETED FORM TO:

Risk Management Division – County of San Bernardino, State of California
222 W. Hospitality Lane, 3rd Floor
San Bernardino, CA 92415-0016

Office: (909) 386-8631
Fax: (909) 382-3212

Revised 9-2011