COUNTY OF GLENN

Filing a Claim Against the County of Glenn

Claims MUST be filed at the following location:

County of Glenn
Willows Memorial Hall
525 W. Sycamore Street, Suite B1
Willows, CA 95988

Subject to the exceptions contained in Government Code section 900 et seq. and the procedure for contained in Government Code section 911.4 for the presentation of late claims, you must file your claim form, by mail or in person, with the Clerk of the Board of Supervisors, 525 W. Sycamore Street, Suite B1, Willows, CA 95988, within the time limits prescribed by Government Code section 911.2, which states: "A claim relating to a cause of action for death or for injury to person or to personal property or growing crops shall be presented as provided in Article 2 (commencing with Section 915) of this chapter not later than six months after the accrual of the cause of action. A claim relating to any other cause of action shall be presented as provided in Article 2 (commencing with Section 915) of this chapter not later than one year after the accrual of the cause of action." The claim must be filed in order to put County on Notice of the Claim.

Clerk of the Board * 525 W. Sycamore Street, Suite B1 * Willows, CA * 95988
Office: (530) 934-6400 * Fax: (530) 934-6419

File With: **Clerk of the Board** Willows Memorial Hall 525 W. Sycamore St., Suite B1 * Willows, CA 95988	**CLAIM FOR DAMAGES** **TO PERSON OR PROPERTY**	**Date Received:** (For Official Use Only)

INSTRUCTIONS

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 or any other course of action must be filed not later than 1 year after the occurrence. (Gov. Code Sec. 911.2.)
3. Read entire claim form before filing.
4. See page 2 for space to diagram place of accident.
5. This claim form must be signed on page 2 at bottom.

Attach separate sheets, if necessary, to give full details. SIGN EACH ADDITIONAL SHEET.

TO: (Name of agency)		Date of Birth of Claimant
* Name of Claimant		Occupation of Claimant
Home Address of Claimant	City and State	Home Telephone Number
Business Address of Claimant	City and State	Business Telephone Number
* Give address and telephone number to which you desire notices or communications to be sent regarding this claim:		Claimant's Social Security No.

* When did DAMAGE or INJURY occur? Date_____Time_____ If claim is for Indemnity, give date you were served with a complaint: Date:	* Names of any agency employees involved in INJURY or DAMAGE

Where did DAMAGE or INJURY occur? Describe fully, and locate on diagram on reverse side of this sheet. If possible and where appropriate, give street names and address and measurements from landmarks:

Describe in detail how the DAMAGE or INJURY occurred.

Why do you claim the agency is responsible?

Describe in detail each INJURY or DAMAGE

See Page 2

THIS CLAIM MUST BE SIGNED ON PAGE 2

Note: Information is **mandatory** where items are marked by (*)

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Name of Claimant: _____

The amount claimed if under $10,000.00, as of the date of presentation of this claim, is computed as follows:

Damages incurred to date (exact):
- Damage to Property.....$_____
- Expenses for medical and hospital care .....$_____
- Loss of earnings .....$_____
- Special damages for .....$_____
- General damages .....$_____

Total damages incurred to date .....$_____

Estimated future damages as far as known:
- Future expenses for medical and hospital care .....$_____
- Future loss of earnings .....$_____
- Other possible special damages…. .....$_____
- Future general damages .....$_____

Total estimate future damages .....$_____

Total amount claimed as of date of presentation of this claim: $_____ (If less than $10,000)

Was damage and/or injury investigated by Police, Sheriff or CHP?_____ If so, what city?_____
Were paramedics or ambulance called?_____ If so, name city or ambulance_____
If injured, state date, time, name and address of doctor of your first visit _____

WITNESSES to DAMAGE or INJURY: List all persons and addresses of persons known to have information:
- Name_____Address_____Phone_____
- Name_____Address_____Phone_____
- Name_____Address_____Phone_____
- Name_____Address_____Phone_____
- Name_____Address_____Phone_____
- Name_____Address_____Phone_____

DOCTORS and HOSPITALS:
- Hospital_____Address_____Date Hospitalized_____
- Doctor_____Address_____Date of Treatment_____
- Doctor_____Address_____Date of Treatment_____

READ CAREFULLY

For all accident claims complete a diagram in the space provided below, (including North, East, South, and West). Indicate place of accident by "X" and by showing house numbers or distances to street corners. If Agency Vehicle was involved, designate by letter "A" location of Agency Vehicle when you first saw it, and by "B" location of yourself or your vehicle when you first saw Agency vehicle; location of vehicle at time of accident by "A-1" and location of yourself or your vehicle at the time of the accident by "B-1" and the point of impact by "X."

Signature of Claimant or person filing on his/her behalf giving relationship to claimant:	Print Name:	Date:

NOTE: CLAIMS MUST BE FILED PURSUANT TO (Gov. Code Sec. 915[a). Presentation of a false claim is a felony (Pen.Code Sec. 72.)

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