



City of San Buenaventura

# CLAIM FOR DAMAGES TO PERSON OR PROPERTY

FILE WITH: City Clerk's Office, 501 Poli Street, Room 204, Ventura, CA 93001

### Instructions

1. Claims for death, injury to person, or damage to personal property or growing crops must be filed no later than six months after the occurrence. (Gov. Code Sec. 911.2.)
2. Claims for damages to real property must be filed no later than one year after the occurrence. (Gov. Code Sec. 911.2.)
3. Read entire claim form before filing.
4. See page 3 for diagram upon which to locate place of accident.
5. This claim form must be signed on page 3 at bottom.
6. Attach separate sheets, if necessary, to give full detail. SIGN EACH SHEET.

**RESERVE FOR FILING STAMP**

CLAIM NO. \_\_\_\_\_

To: **City of San Buenaventura**

Name of Claimant	Claimant Social Security No.	Date of Birth
Home Address of Claimant	City, State & Zip	Home Telephone Number

Is the claim filed on behalf of a minor?  Yes  No

If yes, please state relationship to the minor \_\_\_\_\_ Minor's Date of Birth \_\_\_\_\_

When did DAMAGE or INJURY occur? Date _____ Time _____	Names of any City employee(s) involved in DAMAGE or INJURY.
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When did the incident or event that caused the damage or injury occur, if different from date of damage or injury?

Date: \_\_\_\_\_

When did you discover the damage or injury, if the discovery date is different from the actual date of damage or injury?

Date: \_\_\_\_\_

If this claim is for equitable indemnity, give date claimant was served with the complaint.

Date: \_\_\_\_\_

Where did damage or injury occur? If applicable, include street address, city/county, and direction of travel if car accident.

Describe the specific damage or injury incurred as a result of the incident.

Explain the circumstances that led to the alleged damage or injury. State all facts that support your claim against the City and why you believe the City is responsible for the damage or injury. If known, provide the name(s) of the City employee(s) who allegedly caused the damage or injury.

The amount claimed, 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 for.....\$ \_\_\_\_\_  
Total damages incurred to date .....\$ \_\_\_\_\_

**Estimated prospective damages as far as known:**

Future expenses for medical and hospital care .....\$ \_\_\_\_\_  
Future loss of earnings.....\$ \_\_\_\_\_  
Other prospective special damages .....\$ \_\_\_\_\_  
Prospective general damages.....\$ \_\_\_\_\_  
Total estimate prospective damages: .....\$ \_\_\_\_\_

**Total amount claimed as of date of presentation of this claim:** \$ \_\_\_\_\_

**NOTE:** If this claim exceeds \$10,000:

- Indicate if greater than \$25,000
- Or less than \$25,000

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**INSURANCE INFORMATION: (must be completed if claim involved a motor vehicle)**

- Do you have automobile insurance? Yes  No
- Has claim been filed or will a claim be filed with your insurance company? Yes  No
- Name of your insurance company \_\_\_\_\_
- Policy number \_\_\_\_\_
- Insurance company's mailing address and telephone number (include area code) \_\_\_\_\_  
\_\_\_\_\_
- Amount of deductible \_\_\_\_\_
- Are you the registered owner? Yes  No   
If no, who is? \_\_\_\_\_
- Make of vehicle \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_

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Was damage and/or injury investigated by police? \_\_\_\_\_ If so, name officer(s) involved \_\_\_\_\_

Were paramedics or ambulance called? \_\_\_\_\_ If so, name of the company \_\_\_\_\_

If injured, state date, time, name and address of doctor of your first doctor visit \_\_\_\_\_

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**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 \_\_\_\_\_

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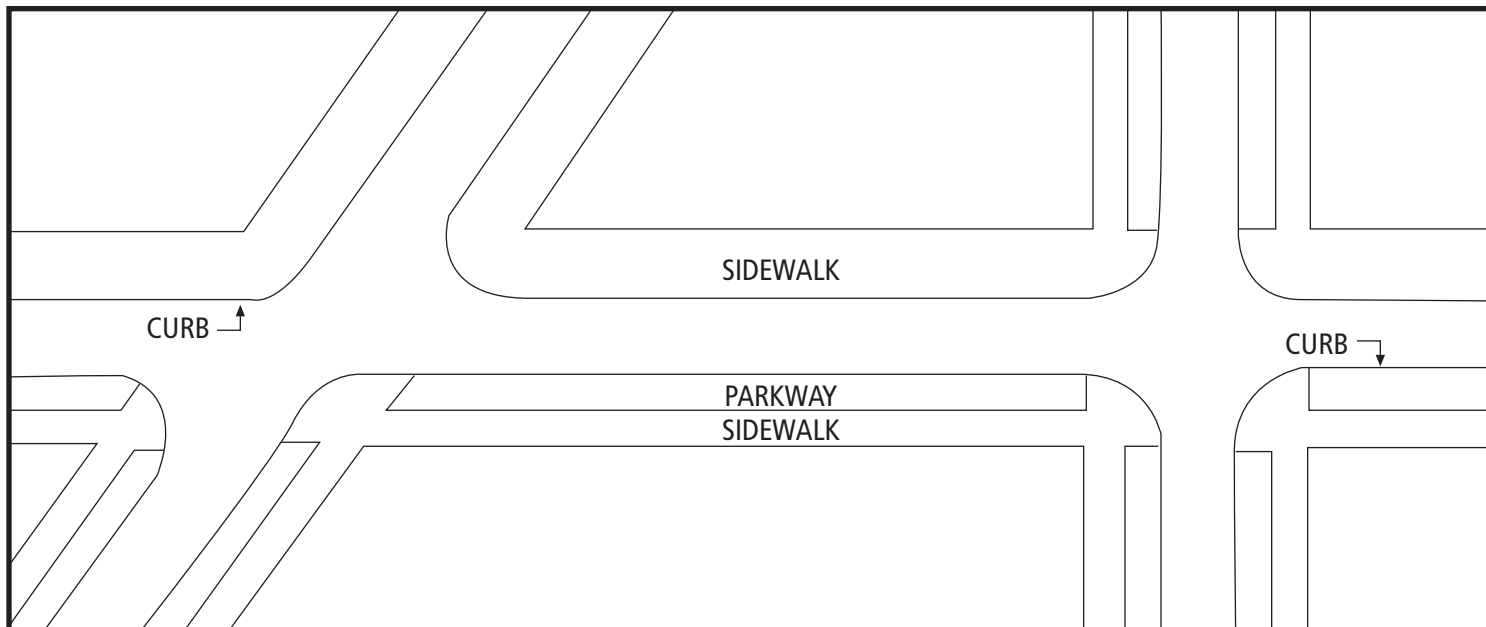
**DOCTORS or HOSPITALS:**

Doctor \_\_\_\_\_ Address \_\_\_\_\_ Date Visited \_\_\_\_\_  
Doctor \_\_\_\_\_ Address \_\_\_\_\_ Date Visited \_\_\_\_\_

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**READ CAREFULLY**

For all accident claims, place on following diagram names of streets, including North, East, South, and West; indicate place of accident by "X" and showing house numbers or distances to street corners. If another vehicle was involved, designate by letter "A" location of other vehicle when you first saw it, and by "B" location of yourself or your vehicle when you first saw other vehicle; location of other 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." **NOTE:** If diagrams below do not fit the situation, attach a proper diagram signed by claimant.



Signature of Claimant or person filing on his/her behalf giving relationship to Claimant:

Typed or Printed Name:

Date:

**Representative Information (must be completed, if an attorney or authorized representative files the claim)**

Name of Attorney/Representative: \_\_\_\_\_

Telephone No. (include area code): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**IMPORTANT INFORMATION:**

- This claim must be signed by the claimant or his/her authorized representative.
- Claims must be filed with City Clerk (Govt. Code Sec. 915a). Presentation of false claim is a felony (Penal Code Sec. 72).
- All Claims filed against the City must be properly filed with the City Clerk's Office, in hard copy, on the City-produced Claim Form. Completed claim forms must be filed with an original signature at the office of the City Clerk, and should include estimates, receipts and/or photographs supporting the loss.

In compliance with the Americans with Disabilities Act, this document is available in alternate formats by contacting the City Clerk's Office at (805) 658-4787 or through the California Relay Service.