

CLAIM AGAINST THE _____ SCHOOL DISTRICT

DISTRICT NAME: _____
ADDRESS: _____
ATTN: _____

NAME OF CLAIMANT	MAILING ADDRESS	ZIP	TELEPHONE
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INSTRUCTIONS

Claims against the above school district must be filed with the Board of Education within six (6) months after incident occurred, as required by Government Code Section 911.2.

Where space is insufficient, please use additional paper, include your name, identify each item of information by the paragraph number and sign each sheet.

1. OCCURRENCE OR TRANSACTION CAUSING THIS CLAIM		
DATE	TIME	PLACE

2. STATEMENT OF INCIDENT (Specify the particular act or omission you claim caused the injury, damage or loss, if known.)
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3. DESCRIPTION OF CIRCUMSTANCES
STATEMENT OF HOW THE DISTRICT OR ITS EMPLOYEES WERE AT FAULT (include names of persons causing injury damage or loss - if not known, state "not known.")

4. DESCRIPTION OF INCURRED INDEBTEDNESS, OBLIGATION, INJURY, DAMAGE OR LOSS	
a. GENERAL DESCRIPTION: (So far as known as of the date of this claim)	c. NAME OF PERSON INJURED _____ DESCRIPTION OF PERSONAL INJURY _____
b. NAME OF PERSONS/s CAUSING THE ABOVE	d. NAME OF PROPERTY OWNER _____ DESCRIPTION OF PROPERTY DAMAGED _____

5. CLAIM	
a. AMOUNT CLAIMED AS OF DATE OF THIS CLAIM: \$ _____	c. TOTAL AMOUNT OF CLAIM: \$ _____ (Attach estimates or bills in support of claim.)
b. ESTIMATED AMOUNT OF ANY PROSPECTIVE INJURY, DAMAGE OR LOSS. \$ _____	d. BASIS OF COMPUTATION OF AMOUNT CLAIMED

6. EYEWITNESSES, ATTENDING PHYSICIAN, HOSPITAL, ETC.		
NAME	ADDRESS	TELEPHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

I certify under penalty of perjury that I know the above to be true and correct of my own knowledge.

SIGNATURE OF CLAIMANT

DATE OF CLAIM

(IF MORE SPACE IS NEEDED, PLEASE ATTACH ADDITIONAL PAGES AS NECESSARY.)