SANTA PAULA UNIFIED SCHOOL DISTRICT

Risk Management Office
500 E. Santa Barbara Street, Santa Paula, CA 93060
Phone: (805) 933-8800 ex. 9802 • Fax: (805) 525-6128

VERIFIED CLAIM FORM
Damages to Person or Property

Instructions	Date Stamp
1. Claims to death, injury to person or property must be filed not later than six (6) months after the occurrence (Government Code § 911.2) 2. Claim for damages to real property must be filed not later than one (1) year after the occurrence (Government Code § 911.2) 3. Read entire claim form before filing 4. This claim form must be signed on page 2 at the bottom 5. Attach separate sheets, if necessary, to give full details. PLEASE SIGN EACH SHEET	

To: **Santa Paula Unified School District** _____
(School District) (School Name)

_____ _____
Name of Claimant Date of Birth

_____ _____
Home Address of Claimant City, State, Zip Social Security Number

_____ _____
Business Address of Claimant City, State, Zip Preferred Telephone

_____
Give address and telephone number to which you desire notices to be sent

_____ _____
Date and time of Injury, Damages, or Loss Location (exact location)

Nature of Injury, Damages, or Loss:

_____

_____

If no injuries, so state:

_____

The circumstances giving rise to this claim are as follows:

_____

_____

_____

_____

Why do you claim the district or school is responsible?

_____

_____

The names of the public employees causing the claimant's injuries are:

_____

_____

If the amount of the claim is less than $10,000, please itemize expenses related to the claim:

_____

_____

_____

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

If the amount of the claim exceeds $10,000, indicate the following: ❑ Limited Jurisdiction (less than $25,000),
❑ Unlimited Jurisdiction

Was injury or damage investigated by police? ❑ Yes ❑ No _____
Police Department and Report Number

Were paramedics or ambulance called? ❑ Yes ❑ No _____
Fire Department or Ambulance Company

Witnesses:

Name	Address	Telephone
Name	Address	Telephone
Name	Address	Telephone

Hospitals, Doctors, Medical Providers:

Hospital	Address	Telephone
Doctor or other Provider	Address	Telephone
Doctor or other Provider	Address	Telephone

The undersigned states that he or she is the person making the above stated claim, or is a person representing said claim and acting on behalf of the claimant above named, and declares under penalty of perjury that the foregoing is true and correct insofar as is known as of this date.

Date _____ City, State _____

Signature of Claimant or Authorized Representative _____ Relationship to Claimant _____