District Administration
15959 East Gale Avenue
City of Industry, CA 91745

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
CLAIM FOR DAMAGES TO PERSON OR PROPERTY

Mailing Address:
Post Office Box 60002
City of Industry, CA 91716-0002

INSTRUCTIONS

1. Claims for death, injury to person or to personal property must be filed no later than 6 months after the occurrence. (Gov. Code Sec. 911.2)
2. Claims for damages to real property must be filed no later than 1 year after the occurrence. (Gov. Code Sec. 911.2)
3. Read entire claim form before filing.
4. Attach separate sheets, if necessary, to give full details. SIGN EACH SHEET.

Name of claimant		Date of Birth	Social Security Number
Home Address of Claimant	City and State	Home Telephone Number ( )	
Business Address of Claimant	City and State	Business Telephone Number ( )	

Give address to which you desire notices or communications to be sent regarding this claim.

How did DAMAGE or INJURY occur? Give full particulars, date, time of day:

When did DAMAGE or INJURY occur? Give full particulars, date, time of day:

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

What particular ACT or OMISSION do you claim caused the injury or damage? Give names of school employees causing the injury or damage, if known:

What do you claim is the nature and extent of the damage?

What AMOUNT do you claim on account of each item of injury or damage as of date of presentation of this claim, giving basis of computation:

Give ESTIMATED AMOUNT, as far as known, you claim on account of each item of prospective injury or damage, giving basis of computation. Please submit three estimates for damages.

Do you have insurance coverage? If yes, what is the name, address, telephone number, and policy number of your insurance company? Have you reported this incident to your insurance company?

Insurance payments received, if any:

Expenditures made on account of accident or injury (Date - Item). Please submit copies of all receipts for all expenditures.

Name and address of Witnesses, Doctors and Hospitals:

Signature of Claimant or person filing on his behalf, giving relationship to Claimant	Type or Printed Name	Date:

NOTE: All claimants may be required to be examined as to their claim under oath. Presentation of a false claim is a felony. (Calif. Penal Code)

CLAIMS MUST BE FILED WITH PUBLIC ENTITY (GOV. CODE SEC. 915a)