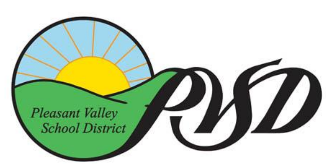

Pleasant Valley School District

Business Services Department
600 Temple Ave. Camarillo, CA 93010
Phone: (805) 389-2100 Fax: (805) 987-5511

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: ______________________________ ______________________________
(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