



COMPTON

UNIFIED SCHOOL DISTRICT

Business and Administrative Services

Risk Management Department

RESERVED FOR FILING STAMP

CLAIM FOR DAMAGES FORM

Instructions:

1. Please Also Submit The Original Claim Via Certified Mail:

Attn: Risk Management Department Compton Unified School District Compton, CA 90221

2. Failure To Provide Sufficient Information May Result In Delays In Claim Processing.

3. Please Direct Any Additional Questions To The Risk Management Department (310)639-4321 Ext. 55131

Please Note:

1. Claims For Death, Injury To Person Or To Personal Property Must Be Filed No Later Than Six (6) Months After The Occurrence (Government Code Section 911.2). This Applies To Occurrences After January 1, 1988.

2. Claims For Damages To Real Property Must Be Filed No Later Than One (1) Year After The Occurrence (Government Code Section 911.2).

3. Review And Complete The Entire Claim For Damages Form Before Filing.

4. This Form Must Be Signed By The Claimant Or A Person On His/Her Behalf (Government Code Section 911.2).

Claimant Information			
Last Name	First Name	Middle Initial	Phone Number
Home Address	City	State	Zip Code
Date Of Damage/Injury	Time Of Damage/Injury	Location Of Damage/Injury	
Claimant Receives Or Is Eligible For SSDI Or Medicare:		Yes ☐	No ☐

If Claimant Is Represented By An Attorney, Provide The Following:			
Name Of Attorney/Law Firm	Contact Number & Email		
Law Firm Address			
Street	City	State	Zip Code

What Injuries/Damages Were Sustained:

How Did The Damage/Injury Occur:

NOTICE: Section 72 of the Penal Code provides that: "Every person who, with intent to defraud, presents for allowance, or for payment to any state board or officer, or to any County, Town, City, District, Ward, or Village Board or Officer, if genuine, and false, fraudulent claim, bill, account, voucher, or writing, is guilty of a felony



C O M P T O N
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Were Police On Scene	Was A Police Report Filed	If Yes, Provide Police Report Number
Yes ☐ No ☐	Yes ☐ No ☐	
Please List Any Names Address Phone Numbers Of Witness Doctors Or Persons Regarding Your Injury Or Damages		
1.		
2.		
3.		
4.		
5.		

State The Amount Claimed As Of The Date Of Presentation Of The Claim, Including The Estimated Amount Of Any Damage/Injury/Loss, Insofar As It May Be Known At The Time Of Presentation Of This Claim, Together With The Basis Of Computation Of The Amount Claimed, With Estimates And Bills, If Appropriate.
If The Dollar Amount Of The Claim Is More Than \$10,000.00, No Dollar Amount Will Be Stated But Please Indicate Whether The Claim Is A Limited Civil Claim (Total Dollar Amount Less Than \$25,000.00):
Limited Civil Case: Yes ☐ No ☐

Please Sign And Date This Form. If The Signer Is Not The Claimant, Indicate The Relationship Of The Signer To The Claimant (i.e. Parent/Legal Guardian/Attorney)

I Hereby Certify Under Penalty Of Perjury That The Facts Hereinabove Set Forth Are True And Correct To The Best Of My Knowledge.

Signature Of Claimant	(Relationship If Not Claimant)	Date
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EMAIL FORM

CLEAR FORM

PRINT FORM

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