

CLAIM AGAINST COUNTY OF SAN BERNARDINO
(CLAIM FORM MUST BE FILLED OUT PROPERLY OR CLAIM WILL BE RETURNED WITHOUT FILING)

DATE: _____

Claim is hereby made against the treasury of the County of San Bernardino, State of California, as follows:

- Less than \$10,000 – State the total amount claimed \$ _____
- More than \$10,000 – Check one of the boxes:
 - Municipal Court Jurisdiction (\$10,000 - \$25,000)
 - Superior Court Jurisdiction (\$25,001 and up)

Claimant makes the following statements in support of the claim:

1. Name of Claimant: _____
First Middle Last (Area Code and Phone No.)

2. Address of Claimant: _____
Street City Zip Code

Gender: ___ Male ___ Female Date of Birth: _____ SS#: _____
***** (The information Requested is Mandatory if Presenting a Claim for Bodily Injury) *****

3. Notices concerning claim should be sent to:

Name Address Zip Code (Area Code and Phone No.)

4. Circumstances giving rise to claim are as follows: _____

5. Date, Time and Place (city, street, cross-street) damage occurred and nature thereof: _____

6. Public property and/or public officers or employees causing injury, damage or loss:

7. Name, address and telephone number of witnesses: _____

8. Basis of computation of claimed amount is as follows:

Medical expenses to date _____	Loss wages _____
Estimated future medical expenses _____	General damages _____
Other expenses _____	Property damage _____
Other damages _____	

Claimant or Representative (Signature)

RETURN COMPLETED FORM TO:
Risk Management Division – County of San Bernardino, State of California
222 W. Hospitality Lane, 3rd Floor
San Bernardino, CA 92415-0016

Office: (909) 386-8631
Fax: (909) 382-3212