CITY CLERKS DATE STAMP:

CITY OF WATSONVILLE

LIABILITY CLAIM FOR DAMAGES
TO PERSON OR PROPERTY

CLAIM NO. _____

RETURN TO:

CITY OF WATSONVILLE
OFFICE OF THE CITY CLERK
275 MAIN ST., SUITE 400 (4th Floor)
WATSONVILLE CA 95076
Tel: (831) 768-3040

1. Claims for death, injury to person, or to personal property must be filed not later than six (6) months after the occurrence (Gov. Code Sec. 911.2).
2. Claims for damages to real property must be filed not later than one (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.
5. PLEASE PROVIDE TWO (2) ESTIMATES.

_____ _____
NAME OF CLAIMANT DATE OF BIRTH OF CLAIMANT

_____ (_____)_____
HOME ADDRESS OF CLAIMANT CITY/STATE/ZIP PHONE NUMBER

_____ (_____)_____
BUSINESS ADDRESS OF CLAIMANT CITY/STATE/ZIP BUSINESS TELEPHONE

_____
E-MAIL ADDRESS

_____
ADDRESS TO WHICH CLAIMANT DESIRES NOTICES OR COMMUNICATIONS SENT REGARDING THIS CLAIM (If different from home address):

_____
_____

WHEN DID DAMAGE OR INJURY OCCUR?
DATE:_____ TIME:_____ ☐ A.M. ☐ P.M.

PLACE OF ACCIDENT (OCCURRENCE) – **BE SPECIFIC** – Describe fully. Where appropriate, give street names and addresses for landmarks.

_____
_____
_____

HOW DID DAMAGE OR INJURY OCCUR?

_____
_____
_____

WERE POLICE AT SCENE? ☐ YES ☐NO WERE PARAMEDICS AT SCENE? ☐ YES ☐NO

WHAT PARTICULAR **ACT** OR **OMISSION** DO YOU CLAIM CAUSED THE INJURY OR DAMAGES? (Give name of City employee causing the injury or damage, if known.)

_____

_____

_____

GIVE TOTAL AMOUNT OF CLAIM: (Include estimate of amount of any prospective injury or damage?
$_____

HOW WAS THE AMOUNT OF CLAIM COMPUTED? (Be specific, provide copies of doctor bills, repair estimates, etc.)

DAMAGES INCURRED TO DATE:

ITEM/DATE_____ AMOUNT: $_____
ITEM/DATE_____ AMOUNT: $_____
TOTAL AMOUNT CLAIMED AS OF PRESENTATION OF THIS CLAIM: $_____

ESTIMATED PROSPECTIVE DAMAGES AS FAR AS KNOWN:

ITEM/DATE_____ AMOUNT: $_____
ITEM/DATE_____ AMOUNT: $_____
TOTAL ESTIMATED PROSPECTIVE DAMAGES: $_____

WITNESSES TO DAMAGE OR INJURY: (List all persons known to have information. (Use attachment if necessary.)
NAME:_____ NAME:_____
ADDRESS:_____ ADDRESS:_____
TELEPHONE: (_____) _____ TELEPHONE: (_____) _____

IF INJURY, GIVE NAME, ADDRESS, TELEPHONE, DATE & TIME OF DOCTOR(S) OR HOSPITAL(S) VISITED:
DOCTOR:_____ TELEPHONE:_____
ADDRESS:_____ DATE/TIME:_____
HOSPITAL:_____ TELEPHONE:_____
ADDRESS:_____ DATE/TIME:_____

Other Information:

_____

_____

_____

_____ _____
SIGNATURE OF CLAIMANT OR AGENT TYPE OR PRINT NAME DATE

ACTING ON BEHALF OF CLAIMANT

_____
RELATIONSHIP TO CLAIMANT

NOTE: PRESENTATION OF A FALSE CLAIM IS A FELONY (CALIFORNIA PENAL CODE 72)