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| **CUTLER-OROSI JOINT UNIFIED SCHOOL DISTRICT** | | | | | | | | | | | | | | | | | |  | | | **DATE STAMP- RECIEVED** | | | | |
| **CLAIM FOR INJURY OR DAMAGE** | | | | | | | | | | | | | | | | | |  | | |
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|  | | | | | | | | | | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | |  | | |
| **1) Name of Claimant:** | | |  | | | | | | | | | | | | | | | **Age:** | |  | | **Date of Birth:** | | |  |
| **If the claim is for bodily injury, enter social security number:** | | | | | | | | | | | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **2) Responsible Parent /Guardian:** | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Name of other person for legal notification:** | | | | | | | | | | | |  | | | | | | | | | | | | | |
| **Legal mailing address:** | | | | | |  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Telephone Number:** | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **3) Residence Address of Claimant:** | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **4) Date of accident or loss:** | | | | | | | |  | | | | | | | | | | | | | **Time of day:** | |  | | |
| **5) Location of accident:** | | | | |  | | | | | | | | | | | | | | | | | | | | |
| **6) Please describe what happened and why you feel the insured (the District) is responsible:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | | | **(Use additional sheets if necessary)** | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **7) Name(s) of person(s) causing the accident or loss (if any):** | | | | | | | | | | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **8) Amount you are claiming:** | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | **Amount** | | | | | **Reason** | | | | | | **Description** | | | | | | | | | | | | |
|  | **$** |  | | | | | **Medical Expense** | | | | | |  | | | | | | | | | | | | |
|  | **$** |  | | | | | **Property Loss** | | | | | |  | | | | | | | | | | | | |
|  | **$** |  | | | | | **Other** | | | | | |  | | | | | | | | | | | | |
|  | **$** |  | | | | | **TOTAL CLAIM** | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **9) Name(s)and address of witnesses:** | | | | | | | | | |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **10) Does the Claimant have Medicare coverage?** | | | | | | | | | | | | | | **Yes:** |  | | **No:** | |  | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **I declare under penalty of perjury that the above statements are true and correct.** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Signature of Claimant or Representative:** | | | | | | | | | | |  | | | | | | | | | | | | | **Date:** |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NOTICE: CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS: Every person who with intent to defraud, presents for allowance or payment any false or fraudulent claim against a public entity may be guilty of a felony. (See California Penal Code 72)** | | | | | | | | | | | | | | | | | | | | | | | | | |