

**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, 3<sup>rd</sup> Floor  
San Bernardino, CA 92415-0016

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