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
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