Claim Against City of Wheatland

A claim must be filed within six months* after the incident or event occurred. Be sure your claim is against the City of Wheatland and not some other public entity. Attach additional pages as necessary and identify the information by paragraph number. Your completed claim (original) must be mailed or delivered to: **City of Wheatland 111 C Street, Wheatland, CA 95692.**

The undersigned hereby submits the following claim against the City of Wheatland in accordance with the provisions of Government Code Section 910.

1. **Name of Claimant:** _____ **Date of Birth:** _____

   Address of Claimant: _____

   City: _____ **State:** _____ **Zip Code:** _____

   Home Phone: _____ **Work Phone:** _____ **Drivers License State/Number:** _____

   SSN No.: _____ (For purposes of Medicare reporting)

2. **Send Notices Regarding This Claim To:** (List name, mailing address and telephone number if not same as name and address listed above.)

   _____

   _____

   _____

3. **Date of Incident Causing Claim:** _____

   Place (exact and specific location of incident): _____

4. **Circumstances** (Specify the occurrence, event, act, or omission you allege caused the injury or damage for which you are submitting this claim.) _____

   _____

   _____

5. **Action** (Specify action by the entity or its employees that caused alleged damage or injury.)

   _____

   _____

* "***One year*** for a claim relating to any cause of action for other than death, injury to person or to personal property, or growing crops." Government Code Section 911.2

6. **Names of Employees Causing Alleged Incident:** _____

7. **Loss Description** (Describe injury, property damage or loss, as far as is known at this time. If there were no injuries, state "NO INJURIES".) _____

_____

_____

8. **Other Injured Persons** (List names and addresses.) _____

_____

_____

9. **Property Owner** (List name and address of owner of damaged property.) _____

_____

_____

10. **Damages Claimed:** (If total amount exceeds $10,000, no dollar amount shall be included in the claim. Indicate with an ***"X"*** whether jurisdiction over the claim would rest in _____ municipal or _____ superior court.

    Amount claimed as of this date: **$** _____

    Estimated amount of future costs: **$** _____

    Total Amount Claimed: **$** _____

11. **Witnesses, Hospitals, Doctors, etc.** (List names and addresses.) _____

_____

_____

_____

12. **Additional Information** (List any additional information that might be helpful in considering your claim.) _____

_____

_____

WARNING: It is a **Criminal Offense** to file a false claim.
(Penal Code Section 72 and Insurance Code Section 556)

I have read the matters and statements made in the above claim and I know the same to be true of my own knowledge, except as to those matters stated upon information or belief and as to such matters I believe the same to be true. I certify under penalty or perjury that the foregoing is **TRUE** or **CORRECT**.

Signed this _____ day of _____, 20___ at _____ Claimant's Signature _____