



CITY OF WATSONVILLE

LIABILITY CLAIM FOR DAMAGES TO PERSON OR PROPERTY

CITY CLERKS DATE STAMP:

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
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ACTING ON BEHALF OF CLAIMANT

RELATIONSHIP TO CLAIMANT

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