LIABILITY CLAIM AGAINST THE CITY OF BAKERSFIELD

For Damages to Persons and Personal Property
(Government Code Sections 905, 910, and 910.2)

BAKERSFIELD

FILE CLAIMS WITH: **CITY CLERK**
CITY OF BAKERSFIELD
1600 TRUXTUN AVENUE
BAKERSFIELD, CALIFORNIA 93301

1. Claim must be filed with the City Clerk, City of Bakersfield within six (6) months after the accident, event or incident occurred.
2. Make certain the claim is against the City of Bakersfield and not another public entity.
3. Completed forms must be mailed or delivered on time to the City Clerk at the address indicated above. Where space is insufficient, use additional paper and identify information by paragraph number.
4. For other claims, consult the Government Code for filing times and complete the appropriate sections of this claim form.
5. You must sign the claim form at the bottom of page 2, and each attached sheet.
6. **WARNING**: Knowingly filing false claims violates Gov. Code §125650 and Penal Code §72 and can be prosecuted as fraud.

TO THE HONORABLE MAYOR AND CITY COUNCIL, CITY OF BAKERSFIELD, CALIFORNIA:
The undersigned respectfully submits the following claim and information:

(A) Claimant's Information:

1. Full Name of Claimant:	2. Name of Parent or Guardian: (if minor)
3. Date of Birth:	4. Sex: Male/Female
5. Complete Home Address of Claimant:	6. Telephone Numbers: (include area codes) Home: Work: Cell:
7. Business/Work Address of Claimant:	8. Preferred Mailing Address: (for notices to be sent)

(B) The date, place and other circumstances of the occurrence or transaction which gave rise to the claim asserted (be precise as to the exact location):

9. DATE:_____ 10. TIME:_____

11. PLACE:_____
(EXACT LOCATION)

12. CIRCUMSTANCES:_____
(SPECIFY THE PARTICULAR OCCURRENCE, EVENT, ACT OR OMISSION WHICH CAUSED THE INJURY OR DAMAGE)

THIS CLAIM MUST BE SIGNED ON REVERSE SIDE

SEE PAGE 2 (over)

(C) A general description of the injury, damage or loss:

13. NATURE/DESCRIPTION OF INJURIES/DAMAGE:_____

_____

_____

(D) The name, address and telephone number of all witnesses to the injury, damage or loss:

14. NAME ADDRESS TELEPHONE NUMBER

(1)_____

(2)_____

(3)_____

(E) The name(s) of the public employee(s) causing the injury, damage, or loss, if known:

15. NAME(S):_____

16. WHAT ACT/ACTION OF CITY EMPLOYEE(S) CAUSED THE INJURY/DAMAGE?_____

_____

_____

(F) The amount claimed, as of the date of filing of this claim, including the estimated amount of any prospective injury, damage, or loss as it may be known. For property damage, please provide copies of 2 separate repair estimates.

17. AMOUNT CLAIMED TO DATE:_____

18. ESTIMATED FUTURE COSTS:_____

19. AMOUNT OF TOTAL CLAIM:_____
(INCLUDING ALL KNOWN LOSS DAMAGES)

NOTE: Effective January 1, 2010, the Medicare Secondary Payer Act (Federal Law) requires the City to report claims involving payments for bodily injury and/or medical treatments to Medicare. As such, are you eligible to receive Medicare/MediCal for services rendered for injuries sustained as a result of this incident?

_____Yes_____No

If your answer is Yes, your Social Security number may be requested during the process of your claim.

The undersigned states that he or she is the person making the above stated claim, or is a person representing said claim and acting on behalf of the claimant above named, and declares under penalty of perjury that the foregoing is true and correct insofar as is known as of this date.

EXECUTED ON:_____
(DATE)

EXECUTED AT:_____ _____
(CITY/STATE) (SIGNATURE OF CLAIMANT OR CLAIMANT'S REPRESENTATIVE)

NOTE: This document is a public record and may be disclosed/released pursuant to the California Public Records Act.