CLAIM AGAINST THE COUNTY OF SANTA CRUZ

(Pursuant to Section 910 et Seq., Govt. Code)

TO: BOARD OF SUPERVISORS
COUNTY OF SANTA CRUZ
ATTN: Clerk of the Board
Governmental Center
701 Ocean Street, Santa Cruz, CA 95060

1. Claimant's Name: _____

Address: _____

_____

Phone No: _____

P.O. Box to which notices are to be sent: _____

2. Occurrence: _____

Date: _____ Place: _____

3. Circumstances of occurrence or transaction giving rise to claim: _____

_____

_____

_____

4. General description of indebtedness, obligation, injury, damage or loss incurred so far as is now known:

_____

_____

_____

5. Name(s) of public employee(s) causing injury, damage or loss, if known: _____

_____

6. Amount claimed now . . . . . .$_____

Estimated amount of future loss, if known . . . . . .$_____

TOTAL $_____

7. Basis for above computations: _____

_____

8. If the amount claimed is over $10,000, indicate the court of jurisdiction:

_____ Municipal Court _____ Superior Court

CLAIMANT'S SIGNATURE: _____

Note: Claim must be presented to Clerk, Board of Supervisors, within six (6) months after the act, which occasioned the injury.

Americans with Disabilities Act questions or requests for accommodations may be directed to the ADA Coordinator at 454-2962 (TDD 454-2123).

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