



CLAIM AGAINST THE CITY OF WASCO

(Government Code Sections 905, 910 and 910.2 and B.M.C. 3.12)

746 8th St, Wasco CA 93280
Office: (661) 758-7214 Fax: (661) 758-1728

1. Claim must be filed with the City Clerk, City of Wasco within six (6) months after the accident, event or incident occurred.
2. Make certain the claim is against the City of Wasco 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.**

A) Claimant's Information

Claimant Name (First, Middle, Last)

Claimant Address		Claimant Phone Number ()
City	State	Zip

Mailing Address (if different from above)		Name of Parent or Guardian (if minor)
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B) The date, place, and other circumstances of the occurrence or transaction which gave rise to the claim asserted (be detailed with exact location)

Date of Incident (MM/DD/YYYY)	Time
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Location of Incident or Accident

Basis of Claim (specify in exact occurrence, event, act, or omission which caused the injury or damage)

State why you believe the City is responsible for the claim

C) Description of alleged injury, property damage, or loss (use separate sheet if necessary)

Provide information of all witnesses (name, address, telephone number)

D) City Employee Information

Name and Department of City Employee(s) who caused Injury or Loss	City Vehicle Type/Description	License Plate No./ Unit No.

E) Damages Claimed

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. (attach supporting medical bills, invoices, repair estimates, etc)

- 1. Amount claimed as of claim date _____
- 2. Estimated amount of future costs _____
- Total Amount** _____

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 as of this date.

Printed Name of Signatory and Relationship to Claimant

Date

Signature of Claimant of Person Acting On Behalf of Claimant

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