CLAIM AGAINST THE COUNTY OF AMADOR

FILE SIGNED CLAIM FORM IN PERSON OR BY MAIL TO:
Clerk of the Board of Supervisors
810 Court Street, Jackson, CA 95642

Please keep a copy for your records – Print/Type only

(*For Dept. Use Only*)

Reference No. _______________

Claim No. ___________________

1. Claimant's Name, Address and Phone Number(s):

____
Last First M.I.

____
Street or P.O. Box City Zip Code

____
Home Phone Work Cell

2. Address Where Correspondence Should be Sent: (if different from above)

____

3. Date and Location of Accident / Injury / Loss: ____

____

4. Basis of Claim: ____

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5. Itemized List of Claimed Expenses/Damages:

ITEM	DOLLAR AMOUNT
_______________________________________	$ ___________________________
_______________________________________	$ ___________________________
_______________________________________	$ ___________________________

(Attach additional pages if needed)

Please attach any estimates and/or receipts to your claim
*1 estimate if repairs/damages are less than $1000 **2 estimates if over $1000
***Provide Police report if available

TOTAL CLAIM $ ___________________________

6. Describe How Accident / Incident / Loss Occurred and Describe Damage / Injury / Loss Being Claimed:

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(Attach additional pages if needed)

7. Provide the Name(s) of any County Employee(s) Involved, and Provide Witness(es) Name(s) and Phone Number(s):

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WARNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM. (Penal Code section 72; Insurance Code section 556.1)

Date: ___________________________________

Signature of Claimant or Representative: ____