City of Lathrop

390 Towne Centre Drive, Lathrop, CA 95330
Telephone Number (209) 941-7235
www.ci.lathrop.ca.us

CLAIM FORM

(Please Type Or Print)

CLAIM AGAINST _____
(Name of Entity)

Claimant's name:_____

Telephone number:_____

SS# (if have):_____ DOB:_____Gender: ☐ Male ☐ Female ☐ Prefer Not To Answer

Claimant's address: _____

Address where notices about claim are to be sent, if different from above: _____

_____

Date of incident/accident: _____

Date injuries, damages, or losses were discovered: _____

Location of incident/accident: _____

What did entity or employee do to cause this loss, damage, or injury? _____

_____
(Use back of this form or separate sheet if necessary to answer this question in detail.)

What are the names of the entity's employees who caused this injury, damage, or loss (if known)? _____

_____

What specific injuries, damages, or losses did claimant receive? _____

_____
(Use back of this form or separate sheet if necessary to answer this question in detail.)

If the amount of your claim does not exceed $10,000, state the total amount claimed: _____

If the amount of your claim exceeds $10,000, please check one option:

☐ DOES NOT EXCEED $25,000 [Limited Civil Case] ☐ EXCEEDS $25,000 [see Government Code 910(f)]

How was the amount of your claim calculated? Please itemize:_____

_____
(Use back of this form or separate sheet if necessary to answer this question in detail.)

Date Signed: _____ Signature: _____

If signed by representative:

Representative's Name: _____ Telephone #: _____

Address: _____

Relationship to Claimant: _____