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.

Note: This claim and all attachments become Public Record and are scanned into the World Wide Web (Internet). Americans with Disabilities Act questions or requests for accommodations may be directed to the ADA Coordinator at 831-454-2935 (TDD 711).

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