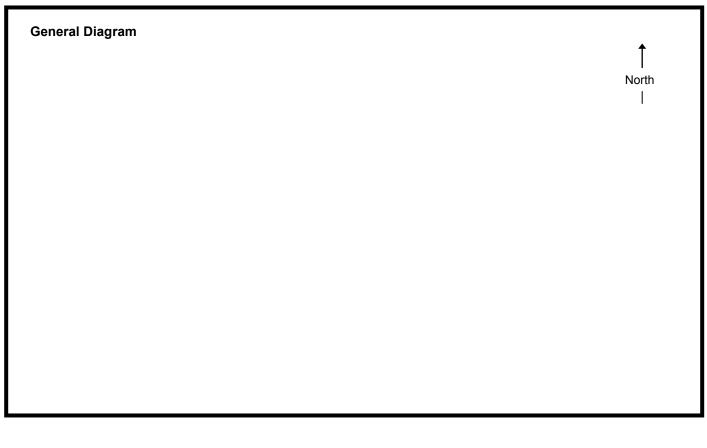
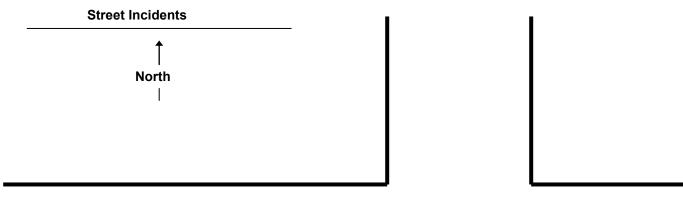
CITY OF MERCED CLAIM FORM

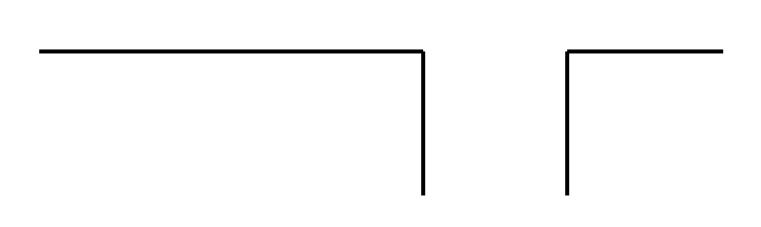
(Please Type or Print)

CLAIM AGAINST				
(Name	e of Entity)			
Claimant's Name		S.S. #	# :	<u>-</u>
Claimant's Date of Birth :	_ Telephone # (_)	
Claimant's Address		Gender:	Male	Female
Address where Notices about Claim are to be sent, if differ	rent from above:			
Date of Incident/Accident/Arrest:				
Date Injuries, Damages or Losses were discovered:				
Location of Incident/Accident/Arrest:				
What did Entity Do to cause this Loss, Damage or Injury?				
(Use back of this form or separate sheet i	•	•	,	
What are the Names of the Entity's Employees who caused this	s Injury, Damage or	Loss (if kn	iown)?	
What specific Injuries, Damages or Losses did Claimant receiv	e?			
(Use back of this form or separate sheet i	if necessary to answer this	s question in	detail.)	
What amount of money is claimant seeking, or if an amount is in earlier Superior and Municipal Courts are consolidated, you must represent				
(Use back of this form or separate sheet i	if necessary to answer this	s question in o	detail.)	
How was this amount calculated (please itemize)?				
(Use back of this form or separate sheet i	if necessary to answer this	s question in o	detail.)	
Date Signed: Signature:				
If signed by Representative:				
Representative's Name				
Address				
Telephone #				
Relationship to Claimant				

DIAGRAMS







PLEASE READ – IMPORTANT!

Your claim must be filed within 6 months of the incident (Government Code 911.2)

Your claim will be forwarded to the City's Risk Manager for investigation. Following that, your claim will be either settled or denied. You will be notified by mail.

If your claim is denied, you will have 6 months from date of denial to initiate an action against the City (Government code 945.6). Our hope is that you will be treated fairly. If you have any questions please call.