



FILE COMPLETED FORM BY MAIL OR IN PERSON AT:

CITY OF MISSION VIEJO
Risk Management
200 Civic Center
Mission Viejo, CA 92691

OFFICE USE ONLY
RESERVE FOR FILING STAMP

CLAIM FOR DAMAGES TO PERSON OR PROPERTY

CLAIM No. _____

A claim must be filed with the City of Mission Viejo within 6 months after which the incident or event occurred. Be sure your claim is against The City of Mission Viejo, not another public entity. Where space is insufficient, please use additional paper and identify information by paragraph number. Completed claims must be mailed or delivered to: Risk Management, The City of Mission Viejo, 200 Civic Center, Mission Viejo, CA 92691.

THE HONORABLE MAYOR AND CITY COUNCIL of the City of Mission Viejo, California

The undersigned respectfully submits the following claim and information relative to damage to persons and/or personal property:

1. **NAME OF CLAIMANT:** _____

a. **ADDRESS OF CLAIMANT:** _____
STREET ADDRESS CITY, STATE ZIP CODE

b. **PHONE NO.** _____ c. **DATE OF BIRTH** _____

2. Name, telephone and post office address to which claimant desires notices to be sent if other than above:

3. Occurrence or event from which the claim arises:

a. **DATE:** _____ b. **TIME:** _____ c. **PLACE** (exact and specific address/location):

d. Describe in detail how the DAMAGE or INURY occurred:

e. What particular action by the City, or its employees, caused the alleged damage or injury?

4. Give a description of the injury, property damage or loss, so far as is known at the time of this claim. If there were no injuries, state "no injuries."

5. Give the name(s) of the City employee(s) causing the damage or injury:

6. Name and address of any other person injured: _____

7. Name and address of the owner of any damaged property: _____

If the amount is less than ten thousand dollars (\$10,000.00), please state:

a. Amount claimed as of this date: \$ _____

b. Estimated amount of future costs: \$ _____

c. Total amount claimed: \$ _____

d. Basis for computation of amounts claimed (include copies of all bills, invoices, estimates, etc.):

9. Names and addresses of all witnesses, hospitals, doctors, etc. _____

a. _____

b. _____

c. _____

d. _____

10. Any additional information that might be helpful in considering claim: _____

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

I have read the matters and statements made in the above claim and I know the same to be true of my own knowledge, except as to those matters stated upon information or belief and as to such matters I believe the same to be true. I certify under penalty of perjury that the foregoing is TRUE and CORRECT.

Signed this _____ day of _____, 20____ at _____

Risk Management,
Mission Viejo, California

CLAIMANT'S SIGNATURE