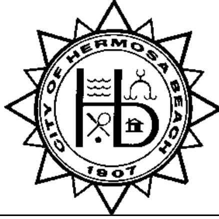


CITY OF HERMOSA BEACH

CLAIM REPORTING FORM FOR ALL PERSONS OR PROPERTY

FILE WITH: City Clerk's Office
City of Hermosa Beach
1315 Valley Drive
Hermosa Beach, CA 90254

RESERVE FOR FILING STAMP

DEPT. NO.________________________

INSTRUCTIONS

1. Claims for death, injury to person or to personal property must be filed not later than six months after the occurrence. (Gov. Code Sec. 911.2)
2. Claims for damages to real property must be filed not later than 1 year after the occurrence. (Gov. Code Sec. 911.2)
3. Read entire claim form before filing.
4. See page 2 for diagram upon which to locate place of accident.
5. This claim form must be signed on page 2 at bottom.
6. Attach separate sheets, if necessary, to give full details.

Name of Claimant

The following information is required by the Federal government for all claims of personal injury:

Social Security Number: ___________________________________

Date of Birth: _________________________

Home Address Of Claimant	Occupation of Claimant
Business Address of Claimant	Home Telephone Number ( )
Give address and telephone number to which you desire notices or communications to be sent regarding this claim.	Business Telephone Number ( )
Date of Damage/Loss/Injury	Time A.M. P.M.

Place of Damage/Loss/Injury

How did damage/loss/injury occur? (Be specific) ________________________

Were Police at scene? Yes ☐ No ☐ Were Paramedics at scene? Yes ☐ No ☐	Report No.

What particular act or omission do you claim caused the damage/loss/injury. ________________________

Name of City employee(s) causing the damage/loss/injury:

The amount claimed, as of the date of presentation of this claim, is computed as follows: (please attach estimates/receipts)

PLEASE REMEMBER TO SIGN CLAIM FORM

Damages incurred to date (exact):		Estimated expenses for medical and hospital care	
Expenses for medical and hospital care	$______	Future expenses for medical and hospital care	$______
Loss of earnings	$______	Future loss of earnings	$______
Special damages for	$______	Other prospective special damages	$______
General damages	$______	Prospective general damages	$______
Total damages incurred to date	$______	Total estimate prospective damages	$______

WITNESSES to DAMAGE or INJURY: LIST ALL PERSONS and addresses of persons known to have information:

Name ______ Address ______ Phone ______

Name ______ Address ______ Phone ______

Name ______ Address ______ Phone ______

DOCTORS and HOSPITALS:

Hospital ______ Address ______ Date Hospitalized ______

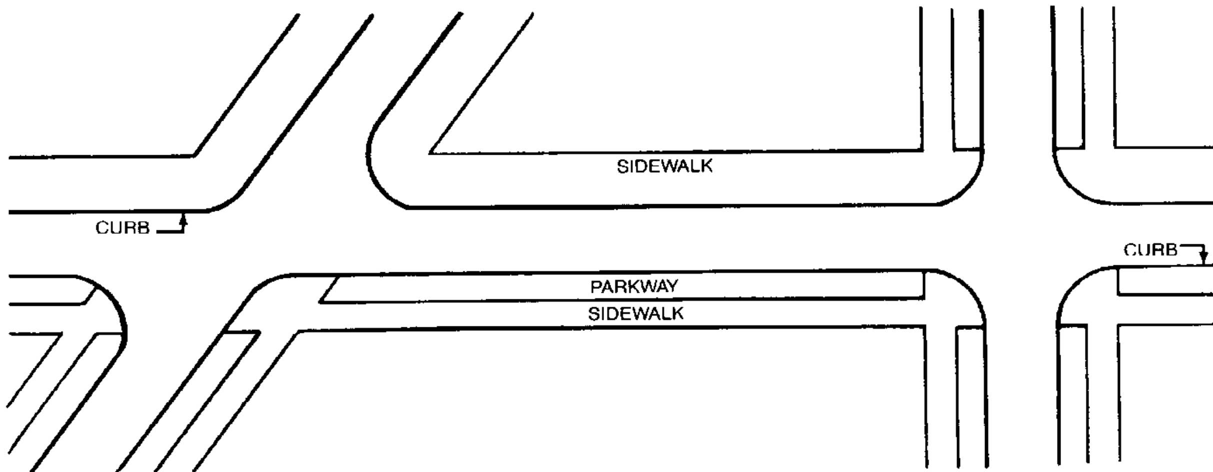
Doctor ______ Address ______ Date of Treatment ______

Doctor ______ Address ______ Date of Treatment ______

READ CAREFULLY

For all accident claims place on following diagram names of streets, including North, East, South, and West; indicate place of accident by "X" and showing house number or distances to street corners. If City vehicle was involved, designate by letter "A" location of City vehicle when you first saw it, and by "B" location of yourself or your vehicle when you first saw City vehicle; location of City vehicle at time of accident by "A-1" and location of yourself or your vehicle at the time of the accident by "B-1" and the point of impact by "X".

NOTE: If diagrams below do not fit the situation, attach hereto a proper diagram signed by claimant.



Signature of claimant or person filing on his behalf giving relationship to Claimant:	Typed Name:	Date:

YOUR CLAIM WILL BE PLACED ON A CITY COUNCIL AGENDA FOR ACTION BY THE CITY COUNCIL. YOUR CLAIM WILL BE IN THE PUBLIC DOMAIN; CLAIM FORMS ARE PUBLIC RECORDS; CITY COUNCIL AGENDAS ARE POSTED ON THE CITY'S WEBSITE; THE MEETING AT WHICH YOUR CLAIM WILL BE CONSIDERED IS BOTH CABLECAST AND STREAMED LIVE OVER THE INTERNET; MINUTES OF THE MEETING WILL REFLECT THE ACTION TAKEN ON YOUR CLAIM AND ARE POSTED ON THE CITY'S WEBSITE.

PLEASE REMEMBER TO SIGN CLAIM FORM