

CLAIM NO. CL__ - __ AGAINST THE CITY OF LA PUENTE

(For Damages to Persons or Personal Property)

Received: _____ via:
U.S. Mail _____
Over the Counter _____

Clerk's Time Stamp

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A claim must be filed with the City Clerk of the City of La Puente within six months or 182 days, whichever is longer, after the incident or event occurred. Be sure your claim is against the City of La Puente, 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 the City Clerk of the City of La Puente, 15900 East Main Street, La Puente, CA 91744. If you have any questions, please call 626-855-1500, 8:00 a.m. to 5:00 p.m., Monday - Friday.
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TO THE HONORABLE MAYOR AND CITY COUNCIL OF THE CITY OF LA PUENTE, 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: _____

B. TELEPHONE NUMBER: (____) _____

C. DATE OF BIRTH: _____

D. SOCIAL SECURITY NO.: _____

E. DRIVER'S LIC. NO.: _____

2. Name, telephone number and mailing 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 location) _____

D. How and under what circumstances did damage or injury occur? Specify the particular occurrence, event, act or omission you claim caused the injury or damage (use additional paper if necessary).

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

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

5. 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":

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

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

8. Damaged claimed:

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

B. Estimated amount of future costs: \$ _____

C. Total amount claimed: \$ _____

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

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

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

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WARNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM. (Penal Code S 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 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 _____, 19 _____, at _____.

Claimant's Signature