



CLAIM FOR DAMAGES FORM

Claim Pursuant to Government Code § 910 and 910.4 et seq.

To be returned to:

Lake Arrowhead Community Services District
Attn: Human Resource Dept.
P. O. Box 700
Lake Arrowhead, CA 92352
Phone: 909-336-7100

A. THE NAME AND MAILING/POST OFFICE ADDRESS OF THE CLAIMANT:

DAYTIME TELEPHONE: _____

EVENING TELEPHONE: _____

B: THE MAILING OR POST OFFICE ADDRESS WHICH THE PERSON PRESENTING THE CLAIM DESIRES NOTICES TO BE SENT:

CELLPHONE: _____

C. THE DATE, PLACE, AND OTHER CIRCUMSTANCES OF THE OCCURRENCE OR TRANSACTION WHICH GAVE RISE TO THE CLAIM ASSERTED:

DATE OF OCCURRENCE: _____

TIME OF OCCURRENCE: _____ AM / PM

PLACE OF OCCURRENCE/PHYSICAL ADDRESS: _____

CIRCUMSTANCES: _____

D. A GENERAL DESCRIPTION OF THE INDEBTEDNESS, OBLIGATION, INJURY, DAMAGE OR LOSS INCURRED SO FAR AS IT MAY BE KNOWN AT THE TIME OF PRESENTATION OF THE CLAIM:

E. THE NAME OR NAMES OF THE PUBLIC EMPLOYEE OR EMPLOYEES CAUSING THE INJURY, DAMAGE, OR LOSS, IF KNOWN.

F. AMOUNT OF CLAIM: (if less than \$10,000.00): \$ _____

JURISDICTION OF CLAIM: MUNICIPAL COURT (CLAIMS TO \$25,000)

SUPERIOR COURT (CLAIMS OVER \$25,000)

BASIS OF COMPUTATION: _____

SIGNATURE OF CLAIMANT OR REPRESENTATIVE: _____

DATE: _____

Section 72 of the Penal Code provides that "every person who, with intent to defraud, presents for allowance or for payment to any State Board or Officer, or to any county, town, city, district, ward, or village, board or officer authorized to allow or pay the same if genuine, any false or fraudulent claim, bill, account, voucher, or writing, is guilty of a felony.