



CLAIM FORM

11201 Harrel Street
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PLEASE RETURN TO: ACCOUNTING MANAGER

COMPLETE THE FOLLOWING, ADDING ADDITIONAL SHEETS IF NECESSARY:

1. PRINT CLAIMANT'S NAME: _____
2. PRINT CLAIMANT'S ADDRESS: _____

(Street or P.O Box Number, City, State, Zip Code)

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3. AMOUNT OF CLAIM \$ _____ (Attach copies of bills/estimates)
 4. PRINT ADDRESS TO WHICH NOTICES ARE TO BE SENT IF DIFFERENT FROM LINE 2:

(Street, P.O Box Number, City, State, Zip Code)

5. DATE OF INCIDENT: _____ TIME OF INCIDENT: _____
LOCATION OF INCIDENT: _____

6. DESCRIBE THE INCIDENT OR ACCIDENT INCLUDING YOUR REASON FOR BELIEVING THAT THE DISTRICT IS LIABLE FOR YOUR DAMAGES (Attach additional sheets if necessary)

7. DESCRIBE ALL DAMAGES WHICH YOU BELIEVE YOU HAVE INCURRED AS RESULT OF THE INCIDENT (Attach additional sheets if necessary)

8. NAME (S) OF PUBLIC EMPLOYEE(S) CAUSING THE DAMAGES YOU ARE CLAIMING:

SIGNATURE OF CLAIMANT

DATE

Any person who, with intent to defraud, presents any false or fraudulent claim may be punished by imprisonment or fine or both.

(Note: Claims must be filed within 180 days of incident. See Government Code Section 900 et seq.)