GENERAL CLAIMS FORM

TO: Vice President of Administrative Services
Imperial Community College District
380 East Aten Road
Imperial, CA 92251

Instructions:

1. Claims for death, injury to person, or to personal property must be filed not later than six (6) months after the occurrence (Gov. Code, Section 911.2).
2. Claims for any other cause of action, including damages to real property, must be filed not later than one (1) year after the accrual of the cause of action (Gov. Code, Section 911.2(b)).
3. Where space is insufficient, please use additional paper, include your name, identify each item of information by the paragraph number and sign each sheet.
4. Claims must be delivered or mailed to the designated District office identified above.
5. Claims submitted only by email or phone do not constitute proper presentation under the Government Claims Act.
6. The District will accept any written claim that complies with Government Code sections 910–910.2 even if not on this form.
7. This form is provided as a convenience and does not constitute legal advice. You may wish to consult an attorney. Completion of this form does not guarantee payment of any claim.

CLAIMANT INFORMATION		
1. Name of Claimant:	2. Date of Birth:	3. Phone No:
4. Address of Claimant:		
5. Name and Address where you wish notices or communications to be sent:		
DETAILS OF INCIDENT		
6. Date when damage occurred:		7. Time when damage occurred:
8. Where did the damage or injury occur? (Be specific: Location at School, Address, N/E Corner of Intersection, etc.)		

9. Describe in detail how damage or injury occurred: (Attach additional sheets or diagrams, if necessary.)

10. Why do you believe the Imperial Valley Community College District is responsible?

WITNESSES; PEOPLE INVOLVED

11. Names of all District employees involved in this injury or damage:

12. Witnesses to injury or damage: (List all persons, with addresses and phone numbers, known to have information.)

13. Were law enforcement emergency agencies called? ☐ Yes ☐ No	Police Dept. and Report No:

14. If a physician was visited because of this injury:
Physician's Name: Date of Visit:

Physician's Address:

MONETARY DAMAGES

15. List damages incurred to date: (Attached copies of receipts or estimates.)	16. If the combined total is less than $10,000, provide the total dollar amount of: *Damages to date:* *Estimated dollar amount of <u>future</u> damages:*

SIGNATURE ***I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.***	
17. Signature of Claimant or person filing on his/her behalf: (Give relationship to Claimant.)	
18. Print or type name of person listed above:	Date: