RETURN IN PERSON TO:
CITY OF LINDSAY RISK MANAGEMENT
251 E Honolulu St.
P.O. Box 369
Lindsay, CA 93247
Office: (559)562-7102 Ext. 8033

CITY OF LINDSAY
CLAIM FORM

Claim Against: _____ (Name of Entity)

Claimant's Name: _____

Claimant's DOB: _____ Claimant's SS#: _____

Claimant's Address: _____

Claimant's Phone Number: _____

Address where Notices related to this Claim shall be sent, if different from above:

_____

Date of incident/accident: _____ Date injury/ damage/ loss discovered: _____

Location of incident/accident:

_____

What did entity or employee do to cause this loss, damage, or injury?
(Use the back of this form or separate sheet if necessary to answer this question in detail.)

_____

_____

Names of the Entity's employees who caused this injury, damage, or loss (if known):

_____

_____

What are Claimant's specific injuries, damages, or losses?

_____

_____

What amount of money is claimant seeking, or if the amount is in excess of $10,000, which is the appropriate court of jurisdiction?
Note: If Superior and Municipal Courts are consolidated, you must represent whether it is a "limited civil case" [see Government Code 910(f)]

_____

_____

How was this amount calculated (please itemize)?

_____

_____

Date Signed: _____ Signature: _____

If signed by a representative:

Representative's Name: _____ Phone #: _____

Address: _____

Relationship to Claimant: _____