

CLAIM AGAINST THE COUNTY OF SANTA CRUZ  
(Pursuant to Section 910 et Seq., Govt. Code)

TO: BOARD OF SUPERVISORS  
COUNTY OF SANTA CRUZ  
ATTN: Clerk of the Board  
Governmental Center  
701 Ocean Street, Santa Cruz, CA 95060

1. Claimant's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone No: \_\_\_\_\_

P.O. Box to which notices are to be sent: \_\_\_\_\_

2. Occurrence: \_\_\_\_\_  
Date: \_\_\_\_\_ Place: \_\_\_\_\_

3. Circumstances of occurrence or transaction giving rise to claim: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. General description of indebtedness, obligation, injury, damage or loss incurred so far as is now known:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Name(s) of public employee(s) causing injury, damage or loss, if known: \_\_\_\_\_  
\_\_\_\_\_

6. Amount claimed now . . . . . \$ \_\_\_\_\_  
Estimated amount of future loss, if known . . . . . \$ \_\_\_\_\_  
TOTAL \$ \_\_\_\_\_

7. Basis for above computations: \_\_\_\_\_  
\_\_\_\_\_

8. If the amount claimed is over \$10,000, indicate the court of jurisdiction:  
\_\_\_\_\_ Municipal Court \_\_\_\_\_ Superior Court

CLAIMANT'S SIGNATURE: \_\_\_\_\_

Note: Claim must be presented to Clerk, Board of Supervisors, within six (6) months after the act, which occasioned the injury.

Americans with Disabilities Act questions or requests for accommodations may be directed to the ADA Coordinator at 454-2962 (TDD 454-2123).