

Mail To:
City Clerk's Office
City of Torrance
3031 Torrance Blvd.
Torrance, California 90503

CLAIM FOR DAMAGES TO PERSON OR PROPERTY

RESERVE FOR FILING STAMP

CLAIM NO. _____

INSTRUCTIONS

1. Claims for death, injury to person or to personal property must be filed not later than six months after the occurrence. (Gov. Code Sec. 911.2)
2. Claims for damages to real property must be filed not later than 1 year after the occurrence. (Gov. Code Sec. 911.2)
3. Read entire claim form before filing.
4. See page 2 for diagram upon which to locate place of accident.
5. This claim form must be signed on page 2 at bottom.
6. Attach separate sheets, if necessary, to give full details. SIGN EACH SHEET.
7. Claim must be filed with the City Clerk. (Gov. Code Sec. 915a)

To: **CITY OF TORRANCE**

Name of Claimant

Date of Birth of Claimant

Home Address of Claimant

City, State and Zip Code

Home Telephone Number

Business Address of Claimant

City, State and Zip Code

Business Telephone Number

Give address and telephone number to which you desire notices or communications to be sent regarding this claim:

Claimant's Social Security Number

When did DAMAGE or INJURY occur?

Date _____ Time _____

If claim is for Equitable Indemnity, give date claimant was served with the complaint:

Date _____

Names of any City of Torrance employees involved in DAMAGE or INJURY

Where did DAMAGE or INJURY occur? Describe fully, and locate on diagram on reverse side of this sheet. Where appropriate, give street names and addresses and measurements from landmarks

Describe in detail how the DAMAGE or INJURY occurred

Why do you claim the City of Torrance is responsible?

Describe in detail each INJURY or DAMAGE

The amount claimed, as of the date of presentation of this claim, is computed as follows:

Damages incurred to date (exact):

Damage to Property \$ _____
 Medical Expenses \$ _____
 Loss of Earnings \$ _____
 Other \$ _____
 Total damages incurred to date \$ _____

Future Damage to Property..... \$ _____
 Future Expenses \$ _____
 Future Loss of Earnings \$ _____
 Future Other \$ _____
 Total Future Damages \$ _____

Total amount claimed as of date of presentation of this claim...\$ _____

Insurance payments received, if any, and name of Insurance Company: _____

Was damage and/or injury investigated by police? _____ If yes, what city? _____

Were paramedics or ambulance called? _____ If yes, name city or ambulance _____

If injured, state date, time, name and address of doctor or your first visit _____

WITNESSES to DAMAGE or INJURY: List all persons and addresses of persons known to have information:

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

DOCTORS and HOSPITALS:

Hospital _____ Address _____ Date Hospitalized _____

Doctor _____ Address _____ Date of Treatment _____

Doctor _____ Address _____ Date of Treatment _____

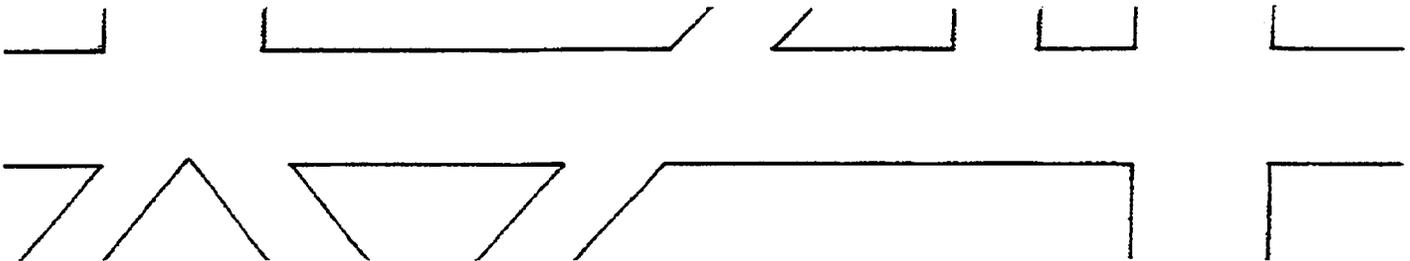
READ CAREFULLY

For all accident claims place on following diagram names of streets including North, East, South, and West; indicate place of accident by "X" and by showing house numbers or distances to street corners.

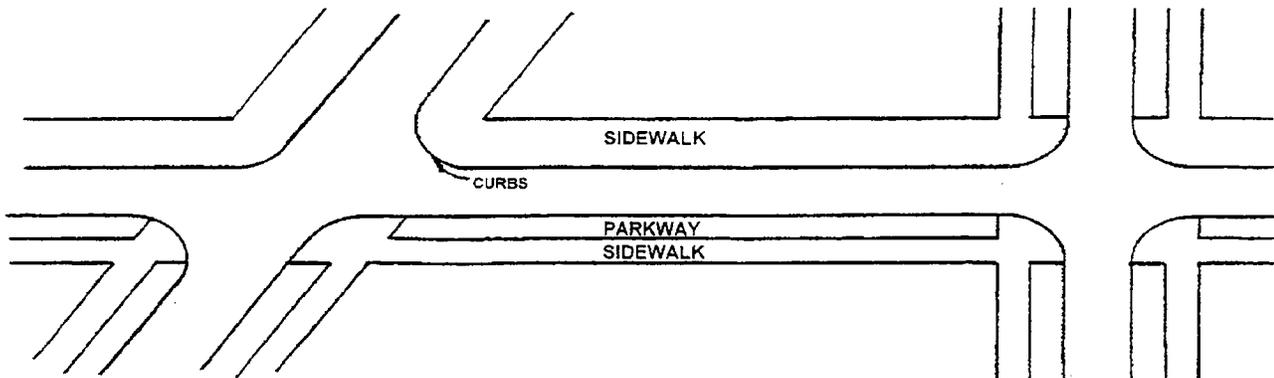
If City vehicle was involved, designate by letter "A" location of City vehicle when you first saw it, and by "B" location of yourself or your vehicle when you first saw City vehicle; location of City vehicle at time of accident by "A-1" and location of yourself or your vehicle at the time of the accident by "B-1" and the point of impact by "X".

NOTE: If diagrams below do not fit the situation, attach hereto a proper diagram signed by claimant.

FOR AUTOMOBILE ACCIDENTS



FOR OTHER ACCIDENTS



I have read the foregoing claim and know the contents thereof; and I certify that the same is true of my own knowledge except as to those matters which are herein stated upon my information and belief; and as to those matters I believe it to be true. I certify (or declare) under penalty of perjury, that the foregoing is true and correct. Signature of Claimant or person filing on his/her behalf giving relationship to Claimant:

Signed: _____ Printed Name: _____ Date: _____