



Ojai Unified School District

414 East Ojai Avenue, P.O. Box 878, Ojai, CA 93024
(805) 640-4300 • Fax (805) 640-4419 • www.ojaiusd.org

VERIFIED CLAIM FORM Damages to Person or Property

Instructions	Date Stamp
<ol style="list-style-type: none"> 1. Claims to death, injury to person or property must be filed not later than six (6) months after the occurrence (Government Code § 911.2) 2. Claim for damages to real property must be filed not later than one (1) year after the occurrence (Government Code § 911.2) 3. Read entire claim form before filing 4. This claim form must be signed on page 2 at the bottom 5. Attach separate sheets, if necessary, to give full details. PLEASE SIGN EACH SHEET 	

To: _____
(School District) (School Name)

Name of Claimant Date of Birth

Home Address of Claimant City, State, Zip Social Security Number

Business Address of Claimant City, State, Zip Preferred Telephone

Give address and telephone number to which you desire notices to be sent

Date and time of Injury, Damages, or Loss Location (exact location)

Nature of Injury, Damages, or Loss:

If no injuries, so state:

The circumstances giving rise to this claim are as follows:

Administration
Dr. Sherrill Knox, Interim Superintendent

Board Members
Atticus Reyes, President, Trustee Area 3
Phil Moncharsh, Vice President, Trustee Area 1
Dr. Jim Halverson, Clerk, Trustee Area 5
Vacant, Trustee Area 2
Vacant, Trustee Area 4

The Heart and Future of the Community

Why do you claim the district or school is responsible?

The names of the public employees causing the claimant's injuries are:

If the amount of the claim is less than \$10,000, please itemize expenses related to the claim:

Total Amount claimed as of date of presentation of this claim (less than \$10,000): \$ _____

If the amount of the claim exceeds \$10,000, indicate the following: Limited Jurisdiction (less than \$25,000),
 Unlimited Jurisdiction

Was injury or damage investigated by police? Yes No

Police Department and Report Number

Were paramedics or ambulance called? Yes No

Fire Department or Ambulance Company

Witnesses:

Name Address Telephone

Name Address Telephone

Name Address Telephone

Hospitals, Doctors, Medical Providers:

Hospital Address Telephone

Doctor or other Provider Address Telephone

Doctor or other Provider Address Telephone

The undersigned states that he or she is the person making the above stated claim, or is a person representing said claim and acting on behalf of the claimant above named, and declares under penalty of perjury that the foregoing is true and correct insofar as is known as of this date.

Date City, State

Signature of Claimant or Authorized Representative Relationship to Claimant