CLAIM AGAINST THE COUNTY OF AMADOR

FILE SIGNED CLAIM FORM IN PERSON OR BY MAIL TO:

Clerk of the Board of Supervisors
810 Court Street, Jackson, CA 95642

Or by electronic mail to:
clerkoftheboard@amadorcounty.gov

(*For Dept. Use Only*)

Reference No. _____

Claim No. _____

Please keep a copy for your records – Print/Type only

1. Claimant's Name, Address and Phone Number(s):

_____
Last First M.I.

_____
Street or P.O. Box City Zip Code

_____
Home Phone Work Cell

2. Address Where Correspondence Should be Sent: (if different from above)

_____

3. Date and Location of Accident / Injury / Loss: _____

_____

4. Basis of Claim: _____

_____

_____

5. Itemized List of Claimed Expenses/Damages:

ITEM DOLLAR AMOUNT

_____ $ _____

_____ $ _____

_____ $ _____
(Attach additional pages if needed)

Please attach any estimates and/or receipts to your claim **TOTAL CLAIM** $ _____
*1 estimate if repairs/damages are less than $1000 **2 estimates if over $1000
***Provide Police report if available

6. Describe How Accident / Incident / Loss Occurred and Describe Damage / Injury / Loss Being Claimed:

_____

_____

_____
(Attach additional pages if needed)

7. Provide the Name(s) of any County Employee(s) Involved, and Provide Witness(es) Name(s) and Phone Number(s):

_____

_____

WARNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM. (Penal Code section 72; Insurance Code section 556.1)

Date: _____

Signature of Claimant or Representative: _____