SUBMIT TO:
Board of Supervisors
3501 Civic Center Drive, Room 329
San Rafael, CA 94903

CLAIM FORM
County of Marin

Name of Claimant:

Address:

Street Number City State Zip

Phone Number:

Home Business

Mailing Address for all Notices:

(If same as above, insert "same")

Date of Injury, Damage or Loss:

Place of Injury, Damage or Loss

(Exact Location)

General Description of Injury, Damage or Loss and Circumstance which Gave Rise to the Claim:

Why is the County of Marin Responsible for the Alleged Injury, Damage or Loss?

Name(s) of County of Marin Employee(s) Causing Alleged Injury, Damage or Loss, if Known:

Witnesses

Name	Address	Phone
Name	Address	Phone

Amount of Claim: $_____

(Attach supporting bills or basis of computation of amount claimed)

DATED: _____

CLAIMANT'S SIGNATURE: _____