

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: _____