Tulare Local Healthcare District

P.O. Box 1136
Tulare, CA 93275-1136
(559) 685-3879

Claim Against Public Entity Form

1.	Name of claimant:		
	Home address:	*Street*	
		City, state, postal code	*Telephone* ( ) -
	Business address:	*Street*	
		City, state, postal code	*Telephone* ( ) -
2.	Mailing address: (Note: List address where all correspondence regarding this claim should be sent)	*Name of Recipient (if other than claimant):*	
		Street	
		City, state, postal code	*Telephone* ( ) -
3.	List name, address, and phone number of any witness(es). Use separate sheet for additional witnesses.		
	Name:		
	Address:	*Street*	
		City, state, postal code	*Telephone* ( ) -
4.	List the date, time, place, and other circumstances of the occurrence that gave rise to the claim asserted:		
	Date:	Time:	Place:
	Tell what happened (*give complete information – note: attach any photographs you may have regarding this claim*):		
5.	Give a general description of the indebtedness, obligation, injury, damage, or loss incurred so far as it may be known at the time of presentation of claim:		
6.	Give the name(s) of the public employee(s) involved, if known:		
	1.	2.	
	3.	4.	
7.	If the actual amount of your claim is less than $10,000, indicate exact amount of your claim, and, if possible, show specific itemization and/or include copies of any documents in support thereof. If the amount of claim exceeds $10,000, a dollar amount should not be included in this claim form. *Note: Attach any photographs, receipts, quotes, or estimates, etc. you may have regarding this claim.*		
	$	Date:	Time:	Claimant's Signature

Investigating manager / supervisor:	
Comments:	
Amount approved for payment:	Administrative Signature:
Comments:	