FULLERTON JOINT UNION HIGH SCHOOL DISTRICT
CLAIM FOR DAMAGES

DIRECTIONS: *Complete and send to:* Fullerton Joint Union High School District, 1051 W. Bastanchury Road, Fullerton, CA 92833 Attn: Risk Management

Name of Claimant: _____
(Injured or damaged party) (Last) (First) (Middle)

_____
(Date of Birth) * (Social Security No.)* (CA Drivers License No.)

Home Address: _____
(Number/Street) (City/State/Zip Code) (Area Code & Phone No.)

Business Address: _____
(Number/Street) (City/State/Zip Code) (Area Code & Phone No.)

Claimant receives or is eligible for SSDI or Medicare* _____ Yes _____ No

Directions: *Indicate to which address you wish notices sent.* *Home* _____ *Business*_____

When Did Injury or Damage occur? _____
(Month/Day/Year) (Day of Week) (Time of Day)

Where Did Injury or Damage Occur? _____
(School site, street address, intersecting streets, or other locations)

How Did Injury or Damage Occur? _____
(Describe accident or occurrence in complete detail/attach additional pages if needed)

_____

_____

Names, Addresses and Phone Numbers of Witnesses, Doctors, Hospitals or persons who may have information regarding Your

Injury or Damages: _____

_____

Names of School Employees Involved: _____

Police Report Number: _____

What Action or Inaction of District Employee(s) Caused Your Injury or Damages? _____

_____

What Injuries or Damages Did You Suffer? _____

_____

State the amount of the claim if it is less than $10,000 _____.

Include the estimated amount of any prospective injury, damage or loss insofar as it may be known at the time the claim is presented and list the basis for the computation of the amount claimed:

_____

_____

If the dollar amount of the claim is more than $10,000, no dollar amount will be stated but please indicate whether the claim is a limited civil claim(total dollar amount less than $25,000): Limited Civil Case: _____ Yes _____ No

Directions: *Sign and date this Form below. If the signer is not the Claimant, indicate the relationship of the signer to the Claimant (parent, attorney etc.) and address.*

_____
(Signature) (Date) (Relationship if not Claimant and address)

Directions: *Attach and include, with this Form, any bills for medical treatment or expenses/estimates for personal property damage.*
*RESPONSES REQUIRED FOR FEDERAL MEDICARE SECONDARY PAYER REPORTING
Note: PRESENTATION OF A FALSE CLAIM IS A FELONY (Refer to CA Penal Code Sec 72)