

**CLAIM AGAINST THE PHELAN PINON HILLS COMMUNITY SERVICES DISTRICT**

Date Received: \_\_\_\_\_

Time Received: \_\_\_\_\_ a.m./p.m.

CLAIM NO.: \_\_\_\_\_

**SUBMIT THE COMPLETED CLAIM FORM WITH ANY ATTACHMENTS TO:**

PHELAN PINON HILLS COMMUNITY SERVICES DISTRICT  
4037 PHELAN ROAD, C-1  
PHELAN, CALIFORNIA 92329  
(760) 868-1212

TO THE BOARD OF DIRECTORS OF THE PHELAN PINON HILLS COMMUNITY SERVICES DISTRICT:

The undersigned respectfully submits the following claim and information relative to a claim for damages:

1. NAME OF CLAIMANT: \_\_\_\_\_ a.

ADDRESS OF CLAIMANT: \_\_\_\_\_

\_\_\_\_\_

(CITY)

(STATE)

(ZIP)

b. PHONE NUMBER: Home: \_\_\_\_\_ Business: \_\_\_\_\_

c. DATE OF BIRTH: \_\_\_\_\_

d. SOCIAL SECURITY NO.: \_\_\_\_\_

e. DRIVER'S LICENSE NO.: \_\_\_\_\_

2. Name, telephone and post office address to which claimant desires notices to be sent if other than above: \_\_\_\_\_

3. Occurrence or event from which the claim arises:

a. DATE: \_\_\_\_\_

b. TIME: \_\_\_\_\_

c. LOCATION (be as specific as possible): \_\_\_\_\_

\_\_\_\_\_

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d. Specify the circumstances of the occurrence, event, act or omission which you claim caused the injury, damage or loss (attach additional pages if necessary):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ e.

State how or in what manner the PHELAN PINON HILLS CSD or its employees were at fault:

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4. Give a description of the injury, damage or loss incurred so far as is known at the time of this claim. If there were no injuries, state no injuries. (If your claim involves a vehicle, include the license, year, make and model.)

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5. Give the name(s) of the PHELAN PINON HILLS Community Services District employee(s) causing injury or loss, if known:\_\_\_\_\_

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6. Name and address of any other person(s) injured:\_\_\_\_\_

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7. Name and address of the owner of any damaged property:\_\_\_\_\_

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8. Amount of damages claimed:

- Less than \$10,000

- More than \$10,000

9. Damages claimed (if less than \$10,000):

a. Amount claimed as of this date \$ \_\_\_\_\_

b. Estimated amount of any future costs \$ \_\_\_\_\_

c. Total amount claimed \$ \_\_\_\_\_

d. Basis for computation of amounts claimed (include copies of all bills, invoices, estimates, etc.): \_\_\_\_\_

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10. Names and addresses of all witnesses, hospitals, doctors, etc. (attach additional pages if necessary):

a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

d. \_\_\_\_\_

11. Any additional information that might be helpful in considering the claim: \_\_\_\_\_

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**WARNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM**  
**(PENAL CODE ' 72; INSURANCE CODE SECTION ' 556.1)**

I HAVE READ THE MATTERS AND STATEMENTS MADE IN THE ABOVE CLAIM AND I KNOW THE SAME TO BE TRUE OF MY OWN KNOWLEDGE,  
EXCEPT AS TO THOSE MATTERS STATED UPON INFORMATION OR BELIEF AND AS TO SUCH MATTERS I BELIEVE THE SAME TO BE TRUE.

I DECLARE UNDER PENALTY OF PERJURY, UNDER THE LAWS OF THE STATE OF CALIFORNIA, THAT THE FOREGOING IS TRUE AND CORRECT.

DATED: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF CLAIMANT OR CLAIMANT'S ATTORNEY

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