City of Indian Wells
Claim for Damages Form

Please mail the original signed form to (copies and faxes not accepted):

Address: Finance Department
City of Indian Wells
44950 Eldorado Dr.
Indian Wells, CA 92210

Hours: 8:00am - 5:00pm, Monday-Friday
Phone: 760-346-2489

You may also bring the form to City Hall at the above address during regular business hours.

Reminder: Please make a copy for your own records.

FORM CONT. 100-A (Rev. 7/01)

RESERVE FOR FILING STAMP

CLAIM NO. _____

CLAIM FOR DAMAGES

TO PERSON OR PROPERTY

INSTRUCTIONS

1. Claims for death, injury to person or to personal property must be filed not later than six months after the occurrence. (Gov. Code Sec. 911.2).
2. Claims for damages relating to any other type of occurrence must be filed not later than one year after the occurrence. (Gov. Code Sec. 911.2).
3. Read entire claim before filing. Claim can be mailed or filed in person. No faxes accepted.
4. See Page 3 for diagram upon which to locate place of accident.
5. This claim form must be signed on Page 3 at bottom.
6. Attach separate sheets, if necessary, to give full details. SIGN EACH SHEET.
7. Fill out in duplicate. ONE COPY TO BE RETAINED BY CLAIMANT.
8. Claim must be filed with CITY CLERK, (Gov. Code Sec. 915A)
   44950 ELDORADO DR., INDIAN WELLS, CA 92210

TO: CITY OF INDIAN WELLS

Name of Claimant | Age of Claimant

Home address of Claimant | City, State and Zip Code | Home Telephone Number

Business address of Claimant | City, State and Zip Code | Business Telephone Number

Give address to which you desire notices or communications to be sent regarding this claim:

How did DAMAGE or INJURY occur? Please include as much detail as possible.

When did DAMAGE or INJURY occur? Please include the date and time of the damage or injury.

Where did DAMAGE or INJURY occur? Please describe fully, and locate on the diagram on the reverse side of this sheet. Where appropriate, please give street names and addresses or measurements from specific landmarks:

What particular ACT or OMISSION do you claim caused the injury or damage? Please give names of City employees causing the injury or damage and identify any vehicles involved by license plate number, if known.

Please list names and address of Witnesses, Doctors and Hospitals:

SEE PAGE 3

THIS CLAIM MUST BE SIGNED AT BOTTOM

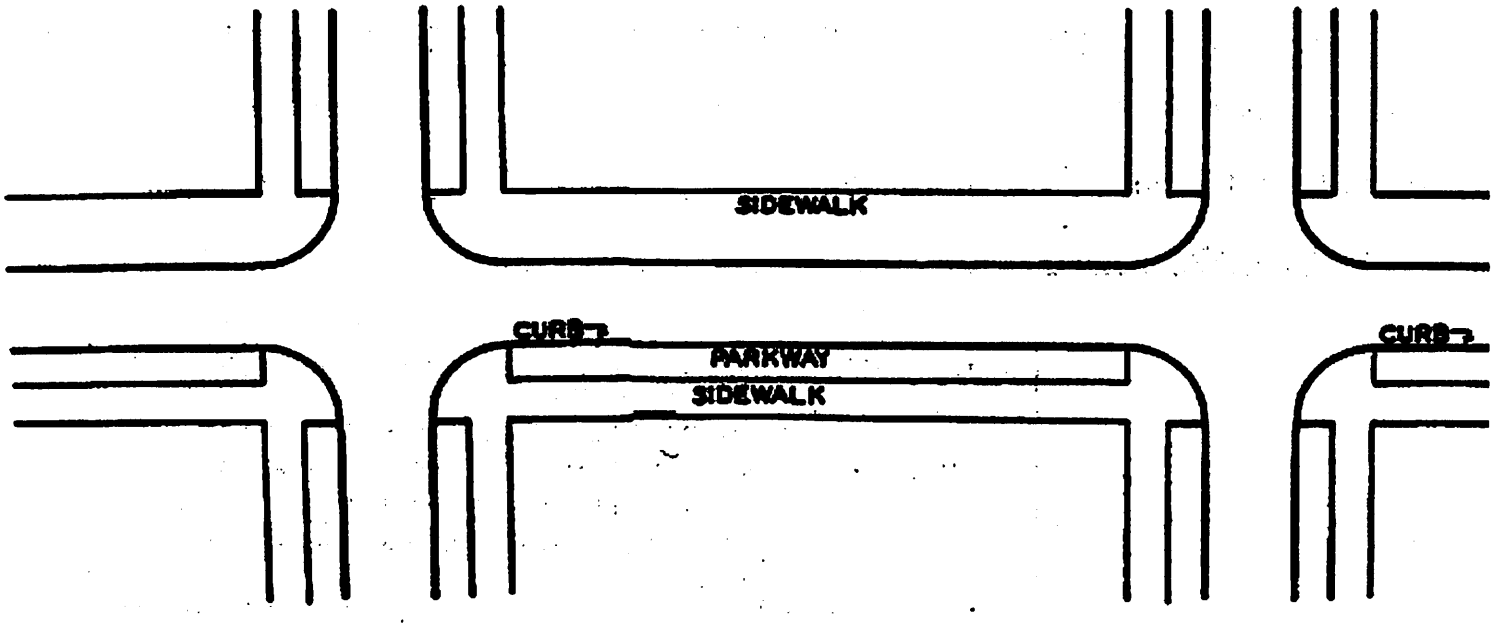
What DAMAGE or INJURIES do you claim resulted? Please give full extent of injuries or damages claimed:

What is the AMOUNT of your claim? Please itemize your damages:

If you have received any insurance payments, please give the names of the insurance companies:

For all accident claims please place on the following diagram the names of the streets where the accident occurred and the nearest cross-streets; indicate the place of the accident by an "X" and by showing the nearest address and distances to street corners. Please indicate where North is on the diagram.

Note: if the diagram does not fit the situation, please attach your own diagram.



Signature of Claimant or person filing on claimant's behalf giving relationship to claimant:	Print Name:	Date: