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FILING A CLAIM AGAINST THE

MERCED COUNTY ASSOCIATION OF GOVERNMENTS

Claims Must be Filed at the Following Location:

Merced County Association of Governments
369 W. 18th Street
Merced, CA 95340

You must file your claim form, by mail or in person, with the Clerk of the Merced County Association of Governments, 369 W. 18th Street, Merced, CA 95340, **within the time prescribed by Government Code section 911.2**, which states, "A claim relating to a cause of action for death or for injury to person or to personal property or growing crops shall be presented as provided in Article 2 (commencing with Section 915) of this chapter not later than six months after the accrual of the cause of action. A claim relating to any other cause of action shall be presented as provided in Article 2 (commencing with Section 915) of this chapter not later than one year after the accrual of the cause of action."

**CLAIM AGAINST THE MERCED COUNTY REGIONAL
ASSOCIATION OF GOVERNMENTS**

Claim Number (Dept. Use Only)

You may file in person or mail form to: Clerk, Merced County Association of Governments, 369 W 18th St., Merced, CA 95340. [Print/Type Only.] Please provide (2) copies of the claim. If you are mailing this claim, also include a self-addressed stamped envelope for the return of your copy. Claims will be stamped and numbered by the Clerk of the Merced County Association of Governments, and one copy will be returned to claimant for claimant's records.

1. Claimant's Name:

Date of Birth:

Last

First

Middle

2. Claimant's Physical Address:

Street

City

State

ZIP

3. Claimant's Mailing Address: (if different from above)

Street (or PO Box)

City

State

ZIP

4. Home Phone Number:

Mobile Phone Number:

() _____ () _____

5. Amount of Claim: \$ _____

6. Date of Accident/Incident/Loss: _____

7. Location of Accident/Incident/Loss: _____

8. Provide your description of how the accident/incident/loss occurred:

Ruled lines for writing.

9. Describe damage/injury/losses being claimed (including prospective damage/injury/ losses to the extent known at the time of claim filing):

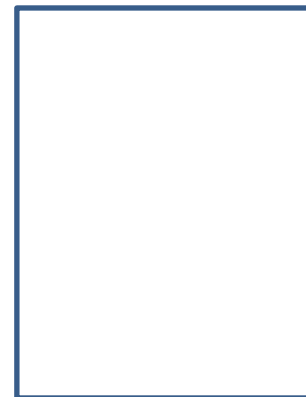
10. Name(s) of public entity/employee(s) causing injury/damage/loss:

11. Names and addresses of any and all witnesses known:

12. If you are claiming you sustained an injury, please provide the names and addresses of any and all medical professionals who treated or are treating you for those claimed injuries:

13. Itemized list of claimed expenses/damages:

Description:	Amount:
	\$
	\$
	\$
	\$
Total Claim: (should equal amount on line 5)	\$
All estimates and itemized receipts <u>must</u> be attached	



Do Not Write in this Space

14. Date:

Signature of Claimant/Representative:

You must present your claim within the time prescribed by Govt. Code Section 911.2.