

CLAIM OF \_\_\_\_\_ )  
 )  
 vs. )  
 )  
 TUOLUMNE COUNTY )  
 \_\_\_\_\_ )

**Application to Present Late Claim**  
**CLAIM FOR**  
**PERSONAL INJURIES**  
(Section 915.4 of the Government Code)



**TO THE TUOLUMNE COUNTY BOARD OF SUPERVISORS:**

You are hereby notified that \_\_\_\_\_, whose address is \_\_\_\_\_, whose date of birth is \_\_\_\_\_, and whose social security number is \_\_\_\_\_, claims damages from the County of Tuolumne in the amount computed as of the date of presentation of this claim, of \$ \_\_\_\_\_.

This claim is based on personal injuries sustained by claimant on or about \_\_\_\_\_, 20\_\_\_\_, in the vicinity of \_\_\_\_\_

under the following circumstances:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The injuries sustained by claimant, as far as known as of the date of presentation of this claim, consist of: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The name(s) of the public employee(s) causing claimant's injuries under the described circumstances is/are:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The employee(s) are employed in the following-named County department(s):

\_\_\_\_\_  
\_\_\_\_\_

The amount claimed, as of the date of presentation of this claim, is computed as follows:

Damages incurred to date:

Expenses for medical and hospital care	\$ _____
Loss of earnings	\$ _____
General damages	\$ _____
Special damages for _____ (itemize)	\$ _____

Total damages incurred to date: \$ \_\_\_\_\_

Estimated prospective damages as far as known: \$ \_\_\_\_\_

Future expenses for medical and hospital care: \$ \_\_\_\_\_

Other prospective special damages: \$ \_\_\_\_\_

Prospective general damages:

Total estimated prospective damages: \$ \_\_\_\_\_

Total amount claimed as of date of presentation of this claim: \$ \_\_\_\_\_

All notices or other communications regarding this claim should be sent to claimant at:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Dated:**

\_\_\_\_\_

\_\_\_\_\_  
Signature of Claimant / Attorney for Claimant

**Claimant Contact Information:**

Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Fax: \_\_\_\_\_

**Attorney for Claimant Contact Information:**

Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Fax: \_\_\_\_\_

**Return Completed Form To:**

*Clerk of the Board of Supervisors  
2 South Green Street  
Sonora, CA 95370*