Indian Valley Community Services District

"Providing services for our community health, well-being, and prosperity."

P.O. Box 899, 127 Crescent St. Greenville CA. 95947
Phone (530) 284-7224, Fax (530) 284-0894
indianvalleycsd.com Email: ivcsd@frontiernet.net

Board of Directors

LMina Admire
Wayne Dannemiller
Lee Anne Schramel
Robert Heard
Bob Orange

CLAIM FORM

(Government Code Sections 910, 910.2, 910.4)

CLAIMANT'S NAME: _____

CLAIMANT'S ADDRESS: _____
No. Street

_____
City State Zip

PHONE: Home (___) _____ **Cell (___)** _____

NAME AND ADDRESS OF PERSON TO WHOM NOTICES REGARDING THIS CLAIM SHOULD BE SENT (If different from above)

_____

_____

_____

DATE OF OCCURRENCE, TRANSACTION OR ACCIDENT GIVING RISE TO THE CLAIM: _____

DATE OF DISCOVERY OF OCCURRENCE, CONDITION OR TRANSACTION; IF DIFFERENT FROM DATE SET FORTH ABOVE (Please indicate earliest date of discovery of occurrence, condition or transaction, which gives rise to the claim. Indicate how the occurrence was discovered)

_____

_____

_____

PLACE OF OCCURRENCE, CONDITION OR TRANSACTION:

_____

_____

GENERAL DESCRIPTION OF OCCURRENCE, ACCIDENT OR TRANSACTION GIVING RISE TO THE CLAIM (Attach additional pages if necessary)

_____

_____

_____

_____

_____

GENERAL DESCRIPTION OF THE OBLIGATION, LOSS, INJURY OR DAMAGE SUFFERED:

_____

_____

_____

_____

PROVIDE NAMES, IF KNOWN, OF ANY PUBLIC EMPLOYEE(s) CAUSING THE INJURY OR LOSS:

_____

_____

_____

TOTAL AMOUNT CLAIMED: $_____

SIGNATURE OF CLAIMANT OR REPRESENTATIVE OF CLAIMANT:

_____

CLAIMANT **REPRESENTATIVE**

_____

DATE SIGNED **PRINT FULL NAME**

_____

REPRESENTATIVE CAPACITY

Send this claim to the following:
Indian Valley Community Services District
PO Box 899
Greenville, CA 95947
Attn: General Manager