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

Lee Anne Schramel
Sarah Holcomb
Philip Shannon
Robert Heard
Mina Admire

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)

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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)

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PLACE OF OCCURRENCE, CONDITION OR TRANSACTION:

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

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

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

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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