YOUR CONSTITUTIONAL RIGHTS ONLY EXIST IF YOU STAND UP FOR THEM. TO DO SO, IF YOUR RIGHTS HAVE BEEN TRAMPLED, SIMPLY FILE WITH RISK MANAGEMENT, THEN FILE WITH THE SUPERIOR COURT...YOU DO NOT NEED AN ATTORNEY!

For more information about how to legally protect your Constitional rights contact the Trinity County Constitutional Law Alliance through www.tradingpostalliance.com

COUNTY OF TRINITY

CLAIM FOR DAMAGES

This claim must be filed with the Board of Supervisors within six (6) months after the accident or event. Where space is insufficient, please use additional paper and identify information by paragraph number. Please include photographs if applicable.
When claim is complete, **mail to:**

TRINITY COUNTY BOARD OF SUPERVISORS OFFICE
ATTN: CLERK OF THE BOARD
Courthouse
P.O. Box 1613
Weaverville, CA 96093

CLAIMANT:

NAME: _____
ADDRESS: _____
_____
TELEPHONE: ( ) _____
DATE OF BIRTH _____
DRIVER'S LICENSE # _____

The undersigned respectfully submits the following claim and information:

1. Address to which claimant desires notice(s) to be sent if other than above:
_____

2. Date, place, and time of occurrence or transaction which gives rise to this claim:
DATE: _____ TIME: _____
PLACE: _____

3. Specify the particular act or omission ***and*** circumstance you believe caused injury and / or damage:
_____
_____
_____
_____

4. Name or names of any employee of the County you believe caused the injury, damage, or loss:
_____
_____

5. Description of property damaged:
_____
_____

6. Owner of property damaged: _____

7. Location of property damaged: _____

8. Description of personal injury (if there was no personal injury, state "**NONE**"):
_____
_____
_____

9. Name of any other person injured: _____
Address of injured person: _____

10. Names and addresses of witnesses, doctors, hospitals, etc.:
NAME ADDRESS TELEPHONE
(1) _____
(2) _____
(3) _____

11. Amount of reimbursement claimed as damages with computation and supporting bills, receipts, or estimates of cost:
(Please attach supporting documents to this form)
_____
_____

12. Any additional information that might be helpful in considering claim:
_____
_____
_____

WARNING! IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM!
(Penal Code 72: Insurance Code 556)

I have read the matters and statements made in the above claim and I know the same to be true of my own knowledge, except as to those matters stated upon information or belief and as to such matters I believe the same to be true. I certify under penalty of perjury that the foregoing is true and correct.

SIGNED THIS _____ DAY OF _____ 20 _____ TIME: _____

_____
CLAIMANT'S SIGNATURE

FOR COURT OR OFFICIAL USE ONLY

Postmark date if received by mail: _____

GOVERNMENT CLAIM—JUDICIAL BRANCH
(Government Code section 910.4)

CLAIMANT

Name of Claimant | Home Telephone | Work Telephone

Mailing Address | City | State | Zip Code

Send notices regarding this claim to *(if different from above):*
Name

Mailing Address | City | State | Zip Code

CLAIM INFORMATION

Date of Incident (Month/Day/Year) | Time of Incident

Location of Incident

Describe the indebtedness, obligation, injury, damage, or loss incurred as a result of the incident.

State the circumstances that gave rise to this claim. (State the facts that support your claim and why you believe the court or another judicial branch entity is responsible for the alleged damage or injury.) If known, provide the name of the official or employee who allegedly caused the injury, damage, or loss (if there is more than one official or employee, name each). If you need more space, please attach additional sheets of paper.

Name of Claimant: _____

If the total amount of your claim is up to $10,000:

Amount of damages as of this date:
Estimated amount of future damages:
Total amount claimed:

If the amount of your claim is more than $10,000, indicate whether your claim would be a limited civil case or an unlimited civil case *(check one)*:

☐ Limited civil (amount is $25,000 or less)
☐ Unlimited civil (amount is more than $25,000)

State how the amount of your claim was computed (include copies of supporting documentation such as billing statements, invoices, receipts, and estimates).

List the names, addresses, and telephone numbers of all witnesses to the incident.

Provide any additional information that might be helpful in considering this claim.

REPRESENTATIVE ***(Complete only if claim is presented by someone acting on claimant's behalf)***

Name of Authorized Representative | Telephone

Mailing Address | City | State | Zip Code

PLEASE NOTE: Presentation of a false claim with intent to defraud is a criminal offense (Penal Code section 72).

~~Signature of Claimant or Authorized Representative~~ *(check one)* Date _____

Deliver or mail this claim form to:

Attention: Court Executive Officer (Claims)
Superior Court of California, County of Trinity
11 Court Street
Weaverville, CA 96093

or

Attention: Court Executive Officer (Claims)
Superior Court of California, County of Trinity
P. O. Box 1258
Weaverville, CA 96093

Paid for by Constitutional Law Alliance of Trinity County