



CENTRAL MARIN SANITATION AGENCY | 1301 Andersen Drive, San Rafael, CA 94901 | Phone 415-459-1455 | Fax 415-459-3971

## CENTRAL MARIN SANITATION AGENCY CLAIM FORM

NAME OF CLAIMANT: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_  
BUSINESS PHONE: \_\_\_\_\_

MAILING ADDRESS (if same as above, insert "same"): \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

Date of Injury, Damage or Loss: \_\_\_\_\_  
Place of Injury, Damage or Loss: \_\_\_\_\_  
(Exact Location)

General Description of injury, damage or loss and circumstance which gave rise to the claim:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why is the Central Marin Sanitation Agency responsible for the alleged injury, damage or loss?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name(s) of Central Marin Sanitation Agency employee(s) causing alleged injury, damage or loss, if known:  
\_\_\_\_\_  
\_\_\_\_\_

Witness(es)--please include name, address and phone number:  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

Amount of claim: \$ \_\_\_\_\_  
(Attach supporting bills or basis of computation of amount claimed)

**SUBMIT TO:**  
Recording Secretary, Board of Commissioners  
Central Marin Sanitation Agency  
1301 Andersen Drive  
San Rafael, CA 94901

CLAIMANT'S SIGNATURE: \_\_\_\_\_ DATED: \_\_\_\_\_