



## 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: \_\_\_\_\_