TO: ALL STAFF

BULLETIN #: 217

APPROVED BY: STEPHANIE L. JAMES
CHIEF PROBATION OFFICER

REPLACES: 11/22/2004

ISSUE DATE: 5/20/2019

SUBJECT: CLAIM FOR DAMAGE OR INJURY

POLICY

To provide employees with a method of reimbursement for damage, loss, or injury during the course of their employment.

PROCEDURES

A. Employee Claim for Damaged Property Reimbursement

1. An employee may submit a claim for the cost of replacing or repairing property or prostheses lost or damaged in the line of duty without fault of employee.

2. The employee must complete and submit the Auditor’s Claim Form (Attachment A).

B. Claim against County by Anyone for Damage or Injury

1. Anyone may submit a County of San Joaquin Claim for Damage or Injury (Attachment B) to the Board of Supervisors.

2. Normally this form is used by a non-employee. However, it can be used by an employee claiming damage or injury as the result of a negligent act or omission by another employee.
## COUNTY OF SAN JOAQUIN
### CLAIM

**PAY TO:**

**ADDRESS:**

**DATE:**

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**EXPENDITURES AUTHORIZED BY:**

**Authorized Signature:**

**Date:**

### Filing Ref.

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<th>DEPT NO</th>
<th>ACCOUNT NO</th>
<th>AMOUNT</th>
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Claim examined and approved pursuant to Gov. Code Sec. 29741

**JEROME C. WILVERDING**

Auditor - Controller

by

**Deputy**

#217 Claim for Damage or Injury  
Attachment A  
Page 2 of 3
County of San Joaquin

CLAIM FOR DAMAGE OR INJURY

INSTRUCTIONS:
Prepare in ink or typewriter. File original and one copy with Clerk of the Board of Supervisors,
San Joaquin County, 44 N. San Joaquin Street, Suite 627, Stockton, California 95202.
Use additional paper as necessary.

Name of Claimant: ________________________________
Last First MI
Home Address/Phone:
Name/Number/Street City/State/Zip Code Phone
Send Correspondence To:
Name/Number/Street City/State/Zip Code Phone

When did Injury or Damage Occur: ____________________
Month/Day/Year Time of Day AM PM

WHERE DID INJURY OR DAMAGE OCCUR:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

HOW DID INJURY OR DAMAGE OCCUR:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Identity of County Vehicle: (if applicable)

Name(s) of County Employee(s) involved:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

WHAT INJURIES OR DAMAGE DID CLAIMANT SUFFER:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

AMOUNT OF DAMAGE OR LOSS:

Property Damage or Cost of Repair
Medical Bills Past/Estimated Future
Loss of Income Past/Future
Other Expenses

Total Claim

I declare under penalty of perjury that the foregoing is true and correct.

Signature ________________________________ Relationship to Signer, if not the Claimant __________________

Date __________________

NOTE: PRESENTATION OF A FALSE CLAIM IS A FELONY

Updated Address Revision 9/09

Attachment B