KernMedical

CLAIM AGAINST THE KERN COUNTY HOSPITAL AUTHORITY

(For damages to persons or personal property)

FOR INTERNAL USE ONLY	Claim Number: _____	Time/Date:
	Mail ☐ Clerk ☐ Other ☐ _____	
Received by:		

A claim must be filed with the Kern County Hospital Authority within 6 months after which the incident or event occurred. Be sure your claim is against the Kern County Hospital Authority, not another public entity. Where space is insufficient, please use additional paper and identify information by paragraph and number.

Completed claims must be mailed to: **Kern Medical Legal Service, PO Box 12319, Bakersfield, CA 93389** or *hand-delivered* to the Clerk of Board at the main hospital campus located at 1700 Mount Vernon Ave, Bakersfield, 93306

Claimant Information

Last Name _____ First Name _____ Middle Name _____

Street Address _____ City _____ Zip _____

Home Phone (include area code) _____ Work Phone (include area code) _____ E-mail Address _____

Birth Date

_____

Name, telephone and post office address to which claimant desires notices to be sent, if other than above:

_____

Claim Information

Date of Occurrence or Event from which the claim arises: _____ Time of Occurrence or Event from which the claim arises: _____

Location, including address (if none, nearest cross street) and city:

_____

Specify the particular occurrence, event, act or omission you claim caused the injury or damage (use additional paper if necessary):

_____

_____

State how the Kern County Hospital Authority or its employees were at fault. Give the name(s) of the department and employee(s) causing the damage or injury:

_____

_____

Give a description of the property damage or loss, as is known at the time of the claim:

_____

_____

Give a description of the injury, as is known at the time of the claim:

_____

_____

Name and address of any other person injured:

_____

Name and address of the owner of any damaged property:

_____

Damages Claimed

Amount claimed as of this date: $_____

Estimated amount of future costs: $_____

Total amount claimed: $_____

If more than ten thousand dollars, would the claim be a limited civil case (less than $25,000)?

Yes ☐ No ☐

Basis for computation of amounts claimed (include copies of all bills, invoices, estimates, etc):

_____

Damaged Vehicle (if applicable)

Make _____ Model _____ Year _____

License Plate Number including Issuing State _____ Mileage _____

Insurance Company Address & Phone Number _____

Insurance Company Address & Phone Number _____

Additional Information

Names and Address of witnesses, hospitals, doctors, etc (Use additional paper if necessary):

1. _____

2. _____

3. _____

Any additional information that might be helpful in considering this claim:

_____

WARNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM (PENAL CODE § 72; INSURANCE CODE § 556.1)

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_____ at _____

Are additional pages included with this claim form?

Yes ☐ No ☐

Claimant's Signature

_____

Original Signature Required