

FOR INTERNAL USE ONLY	Claim Number: _____	Time/Date: _____
Received by: Mail Clerk Other	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	

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 or delivered to: **Kern Medical Legal Service, PO Box 12319, Bakersfield, CA 93389**

The undersigned submits the following claim and information relative to damage to persons and/or personal property.

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

Estimated amount of future costs: \$ _____ Yes No

Total amount claimed: \$ _____

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