FOR COURT OR OFFICIAL USE ONLY

Postmark date if received by mail: _____

GOVERNMENT CLAIM—JUDICIAL BRANCH

(Government Code section 910.4)

CLAIMANT

Name of Claimant | Home Telephone | Work Telephone

Mailing Address | City | State | Zip Code

Send notices regarding this claim to (if different from above):
Name

Mailing Address | City | State | Zip Code

CLAIM INFORMATION

Date of Incident (Month/Day/Year) | Time of Incident

Location of Incident

Describe the indebtedness, obligation, injury, damage, or loss incurred as a result of the incident.

State the circumstances that gave rise to this claim. (State the facts that support your claim and why you believe the court or another judicial branch entity is responsible for the alleged damage or injury.) If known, provide the name of the official or employee who allegedly caused the injury, damage, or loss (if there is more than one official or employee, name each). If you need more space, please attach additional sheets of paper.

Name of Claimant: _____

If the total amount of your claim is up to $10,000:

Amount of damages as of this date: _____
Estimated amount of future damages: _____
Total amount claimed: _____

If the amount of your claim is more than $10,000, indicate whether your claim would be a limited civil case or an unlimited civil case (check one):

☐ Limited civil (amount is $25,000 or less)
☐ Unlimited civil (amount is more than $25,000)

State how the amount of your claim was computed (include copies of supporting documentation such as billing statements, invoices, receipts, and estimates).

List the names, addresses, and telephone numbers of all witnesses to the incident.

Provide any additional information that might be helpful in considering this claim.

REPRESENTATIVE (Complete only if claim is presented by someone acting on claimant's behalf)

Name of Authorized Representative Telephone

Mailing Address City State Zip Code

PLEASE NOTE: Presentation of a false claim with intent to defraud is a criminal offense (Penal Code section 72).

Signature of ☐ Claimant or ☐ Authorized Representative (check one) Date

Deliver or mail this claim form to: ATTN: SASHA MORGAN
SANTA CRUZ SUPERIOR COURT
701 OCEAN ST., ROOM 110
SANTA CRUZ, CA 95060