Stacie Guzman
Executive Director

Joy Young
Clerk

369 W. 18'" Street
Merced, CA 95340
(209) 723-3153
FAX: (209) 723-0322
www.mcagov.org

FILING A CLAIM AGAINST THE

TRANSIT JOINT POWERS AUTHORITY for MERCED COUNTY MERCED COUNTY TRANSIT – "The Bus"

Claims *Must* be Filed at the Following Location:

Transit Joint Powers Authority for Merced County
Merced County Transit – "The Bus"
369 W. 18th Street
Merced, CA 95340

You must file your claim form, by mail or in person, with the Clerk of the Transit Joint Powers Authority for Merced County - Merced County Transit – "The Bus", 369 W. 18th Street, Merced, CA 95340, **within the time prescribed by Government Code section 911.2**, which states, "A claim relating to a cause of action for death or for injury to person or to personal property or growing crops shall be presented as provided in Article 2 (commencing with Section 915) of this chapter not later than six months after the accrual of the cause of action. A claim relating to any other cause of action shall be presented as provided in Article 2 (commencing with Section 915) of this chapter not later than one year after the accrual of the cause of action."

Claim Number (Dept. Use Only)

CLAIM AGAINST THE TRANSIT JOINT POWERS AUTHORITY for MERCED COUNTY
MERCED COUNTY TRANSIT – "The Bus"

You may file in person or mail form to: Clerk, Transit Joint Powers Authority for Merced County Merced County Transit – "The Bus", 369 W 18th St., Merced, CA 95340. [Print/Type Only.] Please provide (2) copies of the claim. If you are mailing this claim, also include a self-addressed stamped envelope for the return of your copy. Claims will be stamped and numbered by the Clerk of the Transit Joint Powers Authority for Merced County - Merced County Transit – "The Bus", and one copy will be returned to claimant for claimant's records.

1. **Claimant's Name:** **Date of Birth:**

____ ____________
Last First Middle

2. **Claimant's Physical Address:**

____
Street City State ZIP

3. **Claimant's Mailing Address: (if different from above)**

____
Street (or PO Box) City State ZIP

4. **Home Phone Number:** **Mobile Phone Number:**

( )______________________ ( )______________________

5. **Amount of Claim:** $______________________________

6. **Date of Accident/Incident/Loss:** ______________________________

7. **Location of Accident/Incident/Loss:** ______________________________

8. **Provide your description of how the accident/incident/loss occurred:**

____

____

____

9. **Describe damage/injury/losses being claimed (including prospective damage/injury/ losses to the extent known at the time of claim filing):**

____

____

10. **Name(s) of public entity/employee(s) causing injury/damage/loss:**

____

____

11. **Names and addresses of any and all witnesses known:**

____

____

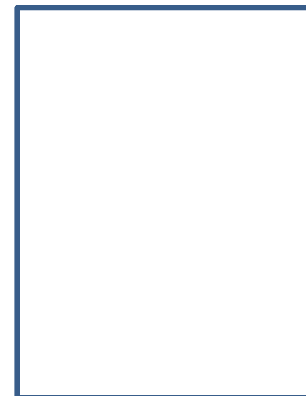
12. **If you are claiming you sustained an injury, please provide the names and addresses of any and all medical professionals who treated or are treating you for those claimed injuries:**

____

____

13. **Itemized list of claimed expenses/damages:**

Description:	**Amount:**
	$
	$
	$
	$
Total Claim: (should equal amount on line 5)	$
All estimates and itemized receipts *must* be attached	



Do Not Write in this Space

14. **Date:** ____________________ **Signature of Claimant/Representative:** ______________________________

<u>You *must* present your claim within the time prescribed by Govt. Code Section 911.2</u>.