NOTICE OF CLAIM FORM

Risk Management Department
63 E. Main St. #101
Mesa, AZ 85201-7422
Phone: 480.472.0365; Fax: 480.472.0107

Office Use Only:

Received By_____ Via

☐ U.S. Mail ☐ Special Delivery
☐ OTC ☐ Fax
☐ Inter-Office ☐ Other

Date:_____

This form can be used to give Mesa Unified School District #4 the information required by Revised Arizona Statute 12-821.01 of a claim against the School District and its employees. That statute requires that certain information must be provided and that if it is not provided within 180 days after a claim accrues, the claim is barred and no action can be taken against the School District or its employees. The School District and its employees are not waiving or precluded from asserting that a claim is barred by, without limitation, the School District or its representatives providing this form for giving notice of a claim, acknowledging receipt of a submitted claim, providing information in connection with a claim, investigating a claim and/or engaging in the negotiation of a possible settlement of all or a portion of a claim.

CLAIMANT INFORMATION (Please complete all areas unless otherwise stated)		
Name: First	MI	Last
Address:	Email address:	
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Date of Birth:	Social Security Number:	
Driver's License Number: (Vehicle Accident Claims Only)		State of Issue:

OCCURRENCE/EVENT INFORMATION		
Date:	Time:	Place: (Be Specific)

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

State why you believe Mesa Unified Schools or its employees were at fault:

INJURY/PROPERTY DAMAGE/LOSS DESCRIPTION

Please describe in detail the injury, property damage or loss (at least as it is known at the time of the filing of the claim):

EMPLOYEES INVOLVED (list the name(s) of the District employees involved in this incident):

See Other Side

OTHER INJURIES (List the names and addresses of any other people injured):

WITNESSES/HOSPITALS/DOCTORS/ETC

Please list the names and addresses of any witnesses and all locations of medical treatment:

ADDITIONAL INFORMATION

Please provide any additional information you feel might be helpful in considering your claim:

THIS AREA MUST BE FILLED OUT COMPLETELY

Amount claimed as of this date:	$	
Estimated amount of future costs (if any):	$	*Please Specify Below
Total amount claimed:	$	

Basis for amount claimed (include copies of all bills, invoices, estimates, etc.):

*

WARNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM (Penal Code ARS 13-3710; Insurance code 44-1220)

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 of belief provided by others 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.

Claimant's Signature:	Date:
Parent or Guardian Signature: (if claimant is a minor)	Date: