

# CLAIM FOR DAMAGES FORM CITY OF CENTRALIA

Date Claim Form  
Received by Member:

Please take note that \_\_\_\_\_, who resides at \_\_\_\_\_,  
\_\_\_\_\_, mailing address \_\_\_\_\_,  
home phone # \_\_\_\_\_, work phone# \_\_\_\_\_, whose prior address for 6 months prior to  
the incident was \_\_\_\_\_, is claiming damages in the sum of  
\$ \_\_\_\_\_ arising out of the following circumstances listed below.

DATE OF OCCURRENCE: \_\_\_\_\_ TIME: \_\_\_\_\_

LOCATION OF OCCURRENCE: \_\_\_\_\_

## DESCRIPTION:

1. Describe occurrence explaining the nature of the defects or acts of negligence causing damages.(attach an extra sheet for additional information, if needed)

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3. Attach copies of all documentation relating to expenses, injuries, losses, and/or estimates for repair.

4. Have you submitted a claim for damages to your insurance company?  Yes  No

If so, please provide the name of the insurance company: \_\_\_\_\_ and the policy #: \_\_\_\_\_

## **\*\* ADDITIONAL INFORMATION REQUIRED FOR AUTOMOBILE CLAIMS ONLY \*\***

License Plate # \_\_\_\_\_ Driver License # \_\_\_\_\_

Auto Make: \_\_\_\_\_ Model: \_\_\_\_\_ Year: \_\_\_\_\_

Name of Driver

Address

Phone No.

Name of Owner

Address

Phone No.

Name(s) of Passenger(s)	Address	Phone No.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**\* \* NOTE: THIS FORM MUST BE SIGNED IN FRONT OF A NOTARY \* \***

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the claimant for the above described; that I have read the above claim, know the contents thereof and believe the same to be true.

X \_\_\_\_\_

X \_\_\_\_\_

Signature of Claimant(s)

State of Washington County of \_\_\_\_\_

I certify that I know or have satisfactory evidence that \_\_\_\_\_ is the person who appeared before me, and said person acknowledged that (he/she) signed this instrument and acknowledged it to be (his/her) free and voluntary act for the uses and purposes mentioned in the instrument.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

My appointment expires \_\_\_\_\_

City of Centralia  
PO Box 609/118 W. Maple St  
Centralia WA 98531