City of Tempe
City Clerk's Office
31 E. 5th Street, 2nd Floor
Tempe, AZ 85281

CITY OF TEMPE
NOTICE OF CLAIM FORM

For Damages to Persons or Property

NOTE: Please note that Arizona state statute requires that claims must comply with A.R.S. 12-821.01 and must be filed within 180 days after the cause of action accrues. This form is offered by the City of Tempe for convenience purposes only. The Claimant(s) remains solely responsible for ensuring compliance with state law. You are cautioned that you must provide sufficient facts for the City to understand the basis upon which liability is claimed and the facts supporting the amount for which you state the claim can be settled. Claims should be submitted via hand delivery to the City Clerk's Office.

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1. Name of Claimant _____ Spouse Name _____

   Date of Birth _____

2. If Minor, name of Legal Guardian _____

   Guardian's Date of Birth _____

3. Address of Claimant _____

   City _____ State _____ Zip _____

   Home Phone _____ Work Phone _____ Cell _____

4. Occurrence or event from which the claim arises:

   a. Date of Loss _____ b. Time of Loss _____ c. Police Report No. _____

   d. Location of Incident *(exact and specific)*_____

   _____

   e. Describe the specific facts of the occurrence, event, act, or omission you claim caused the injury or damage. *(Use additional paper if necessary)* _____

   _____

   _____

   f. State how or wherein the City of Tempe or its employees were at fault. _____

   _____

   _____

5. Give the name(s) of the City employees having knowledge of or involved in the incident *(if auto accident involving a city vehicle, please provide city vehicle description & license plate number, driver name and department)*

   _____

   _____

   _____

6. Describe claimant's injury, property damage, auto damage (include year, make, and model of vehicle) or loss. If there were no injuries, state "no injuries". Preserve and make available all property items being claimed.

_____

_____

_____

7. Dollar amount requested to settle this incident $_____ **(Must provide amount)**

   a. Basis for computation of amounts claimed *(include copies of all bills, invoices, estimates, receipts etc.)*

_____

_____

8. Name and addresses of all witnesses, hospitals, doctors, etc. _____

_____

_____

9. Any additional information that might be helpful in considering claim: _____

_____

_____

_____

Federal Regulation – Bodily Injury Claims Only
If you are presenting a bodily injury claim, you are required to provide the information requested in this section pursuant to Federal Law – Section 42, United States Code 1395y(b) (7) & (8). For additional information regarding Mandatory Insurer Reporting for Non-Group Health Plans go to www.cms.gov
Injured Party Name _____ *(show Name exactly as it appears on Social Security records)*
Injured party Social Security Number _____
Injured Party Gender ☐ Male ☐ Female Injured Party Date of Birth _____
Medicare, Medicaid (AHCCCS) or SCHIP Health Ins Claim # _____
Is the injured party eligible (or will he/she be eligible within the next 36 months) for Medicare, Medicaid (AHCCCS) or the State Children's health Insurance Program (SCHIP)? ☐ Yes ☐ No

WARNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM (A.R.S. 13-2310 and A.R.S. 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 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___

Claimant Signature _____