CITY OF TENINO

CLAIM FOR INJURY/DAMAGES/LOSS

149 S. Hodgden Street / P O Box 4019
Tenino, WA 98589
(360) 264-2368 FAX (360) 264-5772

(Please Print Clearly)

Name: _____ **Phone:** _____

Physical Address: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Cell/Msg Phone:** _____

Age _____ **Sex** _____ **Occupation:** _____

Please Check All That Apply: **Estimated Loss:** $ _____

☐ Bodily Injury ☐ Property Damage ☐ Loss

Date of Incident: _____ **Time of Incident** _____ ☐ am ☐ pm

Describe Injury/Damages/Loss: _____

Medical Treatment? ☐ Yes ☐ No If yes, where? _____

Witnesses:

Name & Address	**Bus. Phone**	**Res. Phone**

_____ _____

(Signature) *(Date)*

For Internal Use Only

Date Claim Received: _____ Date Submitted to Insurance: _____

By: _____ Title: _____

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6-21-04