Valleywise Health

NOTICE OF CLAIM AGAINST
MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT

DATE OF LOSS	TIME OF LOSS	LOCATION OF LOSS
	☐ AM ☐ PM	

PERSON OR ENTITY AGAINST WHOM THE CLAIM IS ASSERTED (ATTACH ADDITONAL PAGES IF NECESSARY)

CLAIMANT NAME	SOCIAL SECURITY NUMBER* Required to Settle Claim	DATE OF BIRTH	IF MINOR, GIVE PARENT OR GUARDIAN NAME

TELEPHONE		ADDRESS	CITY	STATE	ZIP CODE
Home Work	( ) - ( ) -				

BASIS OF LIABILITY AND DESCRIPTION OF OCCURRENCE (ATTACH ADDITONAL PAGES IF NECESSARY)

DESCRIBE INJURY AND DAMAGES (ATTACH ADDITONAL PAGES IF NECESSARY)

HAVE YOU PREVIOUSLY REPORTED THE INCIDENT TO AN VALLEYWISE EMPLOYEE? YES ☐ NO ☐

IF YES, PLEASE PROVIDE THE NAME OF THE EMPLOYEE AND THE DATE THE INCIDENT WAS REPORTED.

IF PERSON(S) INJURED, LIST THE FOLLOWING INFORMATION ON ALL INJURED PARTIES

Name	Address	City, State, Zip	DOB	Telephone
1				( ) -
2				( ) -

RESPONDING POLICE AGENCY:		REPORT #:	

CLAIMANT VEHICLE INFORMATION

Make	Model	Year	License Plate #

CLAIMANT INSURANCE INFORMATION

Carrier Name	Policy Number	Phone Number
		( ) -

DISTRICT VEHICLE INFORMATION

Unit Number	Department	District Driver	License Plate #

IF WITNESSES ARE AVAILABLE, PROVIDE THE FOLLOWING INFORMATION

Name	Address	City, State, Zip	Telephone
1			( ) -
2			( ) -

Specific amount for which your claim can be settled and the facts supporting that amount: $

Claimant signature: ***Date:***

INCLUDE ADDITIONAL INFORMATION ON SEPARATE SHEET OF PAPER

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If you have questions about this form or your claim, it is your responsibility to seek legal advice on your own and at your expense. Please do not call or otherwise contact any employee of Maricopa County Special Health Care District or any of its officers, boards or Directors to seek assistance with filing a notice of claim or with respect to your claim. No officer, employee, or Director of Maricopa County Special Health Care District is authorized to provide you legal advice or assistance with the preparation or filing of your claim. If you rely on any information furnished directly or indirectly by any officer, employee, or Director of Maricopa County Special Health Care District, you do so at your own risk.

To file a civil lawsuit against an Arizona public entity or employee under State law, a proper claim must first be filed. Please refer to Arizona Revised Statute § 12-821.01, which provides certain requirements with regard to presenting claims and filing lawsuits against Arizona public entities and public employees. Filing a valid claim is your sole responsibility. In addition to providing all information requested on the form, please provide copies of any documents that would support your claim (*e.g.*, estimates, bills, police reports, etc.).

The completed form must be returned by mail or hand delivery to:

Clerk of the Board of Directors
Maricopa County Special Health Care District
2601 E. Roosevelt St.
Phoenix, Arizona 85008

IMPORTANT

For claims against Maricopa County, AZ, individual members of the Maricopa County Board of Supervisors, or other Maricopa County employees, please contact Maricopa County at 602-506-2298 or visit their website at http://www.maricopa.gov/riskmgt/claims.asp.