

SAN FRANCISCO BAY AREA RAPID TRANSIT DISTRICT

Insurance Division 300 Lakeside Drive Oakland, CA 94604-2688

CLAIM AGAINST SAN FRANCISCO BAY AREA RAPID TRANSIT DISTRICT IN ACCORDANCE WITH GOVERNMENT CODE SECTIONS 910 ET SEQ*

*Promptly	complete this form and I	nail to: BART, P.O. Box 126	388, Oakland, CA 94604	-2688, Attn.: Insuranc	e Division
PLEASE PRINT:	LAST NA	WE .		FIRST NAME	INIT.
NAME OF CLAIMANT:					
	STREE			CITY	
MAILING ADDRESS:			STATE	ZiP CO	DE PLUS
	HOME	 	_ 	BUSINESS	
TELEPHONE NO.:		DAY	YEAR	TIME	
DATE OF INCIDENT/OCCURENCE					A.M. □ P.M. □
LOCATION/PLACE OF INCIDE	NT/OCCURENCE:				
(Please be specific, i.e., Stat	tion, train, escalator, stairwa	y, etc.)			
			•		
DESCRIPTION OF OCCURREN	NCE OR INCIDENT:				
				· .	
NATURE OF INJURY, LOSS OF	R DAMAGE RESULTING FR	OM THE ABOVE:			
CAUSE OF INJURY, OR DAMA	GE (State what you believe	caused the injury, loss or dama	ge and state the name or na	mes of the public employ	ee or employees causing such
injury, loss or damage if known)			-		
P					
AMOUNT CLAIMED AS OF DATE	OR PRESENTATION OF CL	AIM AND THE ESTIMATED AMO	OUNT OF FUTURE CLAIM, IF	KNOWN: (Include the bas	sis of computation of the amount
claimed):		*****	······································		_

I understand that, by furnishing thi	is form, BARTD is not acknow	ledging any responsibility for payr	ment of my claim.		
	(DO NO	T DETACH - ALL (3) COPIES AR	E TO BE RETURNED TO BA	RT.)	
D.A. J.	<u></u>				
Dated:	Sign	eu;	,		

*CLAIM MUST BE PRESENTED WITHIN 6 MONTHS OF INCIDENT IN ACCORDANCE WITH GOVERNMENT CODE SECTIONS



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*Promptly complete this form and mail to: BART, P.O. Box 12688, Oakland, CA 94604-2688, Attn.: Insurance Division	
PLEASE PRINT: LAST NAME FIRST NAME INIT.	
NAME OF CLAIMANT:	
STREET CITY	\neg
MAILING ADDRESS: STATE ZIP CODE PLUS	
HOME BUSINESS	\equiv
TELEPHONE NO.: NO.: NO.: NO.: NO.: NO.: NO.: NO.:	
DATE OF INCIDENT/OCCURENCE: A.M. P.M. P.M.	
LOCATION/PLACE OF INCIDENT/OCCURENCE:	
(Please be specific, i.e., Station, train, escalator, stairway, etc.)	
DESCRIPTION OF OCCURRENCE OR INCIDENT:	_
	_
	_
	_
NATURE OF INJURY, LOSS OR DAMAGE RESULTING FROM THE ABOVE:	_
NATORE OF INJURY, 2003 ON DAMAGE RESOLUTION THE ABOVE.	_
	_
CAUSE OF INJURY, OR DAMAGE (State what you believe caused the injury, loss or damage and state the name or names of the public employee or employees causing s	
injury, loss or damage if known):	uGn
injury, loss of damage if knowny.	
	_
	—
AMOUNT CLAIMED AS OF DATE OR PRESENTATION OF CLAIM AND THE ESTIMATED AMOUNT OF FUTURE CLAIM, IF KNOWN: (include the basis of computation of the amount of th	
	IUIIL
claimed):	
· · · · · · · · · · · · · · · · · · ·	
	_
London to the feet of the Company of	
I understand that, by furnishing this form, BARTD is not acknowledging any responsibility for payment of my claim. (DO NOT DETACH - ALL (3) COPIES ARE TO BE RETURNED TO BART.)	
(DO NOT DETACH - ALL (3) COPIES ARE TO BE RETURNED TO BART.)	
Dated: Signed;	

*CLAIM MUST BE PRESENTED WITHIN 6 MONTHS OF INCIDENT IN ACCORDANCE WITH GOVERNMENT CODE SECTIONS