

# COUNTY OF SONOMA CLAIM

• TYPE ONLY -

PAY TO: VENDOR  
NAME  
(ONLY)


VENDOR NUMBER		DOCUMENT NUMBER
TREAS. NO. WARRANT NO.	WT TYPE	PAYMENT DUE DATE

**INSTRUCTIONS TO CLAIMANTS -**  
All claims against the County must be itemized, giving date and character of service rendered or work performed, quantities, description and unit price of articles furnished or delivered.  
All claims should be presented to the authorizing department for certification and filed with the County Auditor-Controller, 585 Fiscal Drive, Santa Rosa, CA 95403, immediately upon completion of service or delivery of articles ordered.

WARRANTS WILL BE MAILED TO CLAIMANT UNLESS SPECIFIED OTHERWISE BELOW:

PICK UP BY SECTION.  PICK UP BY PAYEE  COURIER MAIL

BATCH DATE \_\_\_\_\_  
BATCH NO. \_\_\_\_\_ BATCH KEYS BY \_\_\_\_\_

## PERSONAL PROPERTY

SECTION NAME \_\_\_\_\_

SFX	TC	DOC REF	SUBSIDIARY	INDEX	S/OBJ	PROJECT	AMOUNT	INVOICE NO. OR DESCRIPTION (FOR WARRANT STUB)
A								

1. NARRATIVE DESCRIPTION OF INCIDENT AND DAMAGE

4. PURCHASING AGENT'S VALUATION

REPAIR OR REPLACE COST	BASIS				VALUE A + B
	LIFE	AGE	COND =		

WITNESS TO INCIDENT	NAME OF WITNESS	JOB TITLE	PHONE EXT.

TOTAL VALUATION \$ \_\_\_\_\_

COMMENTS: \_\_\_\_\_

BY: \_\_\_\_\_ DATE \_\_\_\_\_

2. EMPLOYEE VALUATIONS AND CLAIM:

DATE OF LOSS	ITEM (INCLUDE BRAND)	REPAIR OR REPLACE	DATE OF PURCHASE	REPAIR OR REPLACE COST	CONDITION			TOTAL AMOUNT OF CLAIM
					EXC.	AVG.	POOR	

The undersigned, under the penalty of perjury states:  
That the above claim and the items therein set out are true and correct; that no part thereof has been heretofore paid, and that the amount therein is justly due, and that the same is presented within one year after the last item has accrued.

SIGNATURE OF CLAIMANT X \_\_\_\_\_ DATE \_\_\_\_\_

3. DEPARTMENT HEAD REVIEW  
THE CIRCUMSTANCES SURROUNDING THE CLAIM HAVE BEEN INVESTIGATED TO MY SATISFACTION

RECOMMENDATION,  APPROVED  DENIED

DEPARTMENT HEAD APPROVAL \_\_\_\_\_ DATE \_\_\_\_\_

BY: \_\_\_\_\_ DATE \_\_\_\_\_

APPROVED AND ORDERED PAID

5 PERSONNEL DEPARTMENT DETERMINATION

APPROVED  DENIED  
PAYMENT AUTHORIZED \$ \_\_\_\_\_

COMMENTS: \_\_\_\_\_

BY: \_\_\_\_\_ DATE \_\_\_\_\_

I hereby certify that the above computations are correct and the above claim is therefore approved in the sum of

\$ \_\_\_\_\_ COUNTY AUDITOR  
By \_\_\_\_\_ DEPUTY COUNTY AUDITOR