County of Santa Cruz

OFFICE OF THE COUNTY COUNSEL

701 OCEAN STREET, SUITE 505, SANTA CRUZ, CA 950604068
(831) 454-2040 FAX: (831) 454-2115

DANA McRAE, COUNTY COUNSEL

CHIEF ASSISTANT
RAHN GARCIA

Assistants

Deborah Steen	Pamela Fyfe	Sharon Carey- Stronck
Harry A. Oberhelman III	Kim Elizabeth Baskett	Margaret M. Burks
Marie Costa	Julia Hill	David Kendig
Jane M. Scott	Dwight L. Herr	Miriam L. Stombler
Tamyra Rice	Shannon Sullivan	Ligi Coleen Yee

GOVERNMENT TORT CLAIM

RECOMMENDED ACTION

Agenda March 5,2002

To: Board of Supervisors

Re: Claim of John J. Buckley, No. 102-085

Original document and associated materials are on file at the Clerk to the Board of Supervisors.

In regard to the above-referenced claim, this is to recommend that the Board take the following action:

X 1. Reject the claim of John J. Buckley, No. 102-085 and refer to County Counsel.

2. Deny the application to file a late claim on behalf of _____ and refer to County Counsel.

3. Grant the application to file a late claim on behalf of _____ and refer to County Counsel.

4. Approve the claim of _____ in the amount of _____ and reject the balance, if any, and refer to County Counsel.

5. Reject the claim of _____ as insufficiently filed and refer to County Counsel.

cc: Tom Bolich, Director
Department of Public Works

RISK MANAGEMENT

By Janet McKinley
Janet McKinley, Risk Manager

DANA McRAE, COUNTY COUNSEL

By Kim Elizabeth Baskett
Kim Elizabeth Baskett, Assistant County Counsel

PER5107 Word Rev 1/2002

CHP :- NCIC Number 4120 BUCKLEY

RYAN — OFFICER ID :- 14320

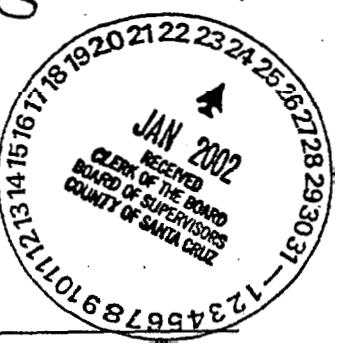
CLAIM AGAINST THE COUNTY OF SANTA CRUZ

(Pursuant to Section 910 et Seq., Govt. Code)

PHONE : 662-0511

102-085

0006



TO: BOARD OF SUPERVISORS
***COUNTY* OF SANTA CRUZ**
ATTN: **Clerk** of the **Board**
GovernmentalCenter
701 Ocean Street, ***Santa*** Cruz, CA 95060

1. Claimant's **Name:** JOHN C. BUCKLEY

Address: _____

Phone No: (408) 203-2558

P.O. Box to which notices are to be sent: PO Box 8127, SAN JOSE, CA 95155

2. Occurrence: FALL FROM BIKE, CAPITOLA ROAD, UNLIT, UN MARKED CONSTRUCTION.

Date: 9-19-2001 Place: CAPITOLA ROAD

3. Circumstances of occurrence or transaction giving rise to claim: FALL FROM BIKE ON TO CONSTRUCTION WORK ON SIDE OF ROAD. FRACTURED ARM, FACIAL INJURY.

4. General description of indebtedness, obligation, injury, damage or loss incurred so far as is now known:
I WOULD LIKE TO CLAIM MY INSURANCE CO-PAYMENTS FOR MEDICAL TREATMENT.

5. Name(s) of public employee(s) causing *injury,* damage or **loss,** if known: NOT KNOWN

6. Amount claimed now ..... $ ≈ 156.45 APROX

Estimated amount of future **loss,** if **known** ..... : $ NOT KNOWN

TOTAL $ _____

7. **Basis** for above computations:.. SUM OF COPAYMENTS FOR MEDICAL + MEDICATION KNOWN TO DATE.

8. **If the amount claimed** is over $10,000, indicate the **court** of jurisdiction:

X Municipal Court — X **Superior Court**

CLAIMANT'S SIGNATURE: John C Buckley

Note. **Claim** must be presented to **Clerk, Board** of Supervisors, **within *six (6)* months** after the act which occasioned the **injury.**

Americans **with** Disabilities Act questions or requests for accommodations may be directed to the **ADA** Coordinator at **454-2962 (TDD 454-2123).**

PER5003

1-24-02

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