

SAN DIEGO UNIFIED SCHOOL DISTRICT
REIMBURSEMENT FOR DAMAGE/LOSS TO EMPLOYEE'S PROPERTY
(Reference Administrative District Procedure 2660)

This form must be submitted within 30 days of the incident or your request may be denied.

Employee Name: _____	Employee ID # (required): _____
Employee Address: _____	City: _____ Zip: _____
Home Phone: _____ Work Phone: _____	Job Title: _____
Assignment Location: _____ Name _____ Number _____	Location where incident occurred: _____
Date of Incident: _____	AMOUNT OF CLAIM: _____

MOTOR VEHICLE DAMAGE

All claims for motor vehicle damage require a School Police or San Diego Police Case Number. Incident must be reported to Police within 24 hours. Contact School Police at (619) 291-7678 or San Diego Police at (619) 531-2000. Two written estimates and a copy of your insurance declaration page must be attached in order to process claim.

Make/Model of Vehicle: _____	Year: _____	Vehicle License Number: _____
Police Case Number: _____	Your Comprehensive Insurance Deductible Amount: _____	
Give details and extent of damage: _____ _____		
Two written estimates attached: _____	Insurance Declaration Page Attached: _____	

DAMAGE TO PERSONAL PROPERTY

Receipts are required and must be attached.

Item(s) damaged: _____
Details of Incident: _____
Receipt(s) attached: _____

I certify the above information to be true to the best of my knowledge, and I assign to the San Diego Unified School District the right of subrogation to the extent of my payment made by the district. I understand that in the case of motor vehicle damage the district will pay my comprehensive insurance coverage deductible only up to a maximum of \$500.00 (If you do not have insurance coverage, the district will pay a maximum of \$500 for automobile damage.)

SIGNATURE OF EMPLOYEE: _____ DATE: _____

I certify that the information set forth above is correct to the best of my knowledge and that this is a reimbursement request within the term and conditions outlined in Administrative District Procedure 2660.

APPROVED: _____ DATE: _____
Principal or Department Head

APPROVED FOR PAYMENT: _____ DATE: _____ \$ _____
Risk Manager

SEND COMPLETED FORM WITH REQUIRED DOCUMENTS ATTACHED TO:
Revere Center
Room 7
Risk Management Department