



**TOTAL AMOUNT CLAIMED AS OF PRESENTATION OF THIS CLAIM:**

\$ 500,000.00

**ESTIMATED PROSPECTIVE DAMAGES, AS FAR AS KNOWN:**

Item/Date: \_\_\_\_\_

2024 DEC-3 AM 9:00  
CITY OF RIALTO

Item/Date: \_\_\_\_\_

Amount: \$ 15,000,000.00  
RECEIVED  
C/S CLERK

**TOTAL ESTIMATED AMOUNT PROSPECTIVE DAMAGES:**

**7. WITNESSES TO DAMAGE OR INJURY** List all persons known to have information (attach additional pages, if necessary)

NAME: Jonathan Albert Escobar

NAME: Officer Carina Magallanes, CHP

ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

TELEPHONE: ( ) \_\_\_\_\_

**8. IF INJURED, PROVIDE NAME, CONTACT INFORMATION AND DATE/TIME DOCTOR(S) OR HOSPITAL(S) VISITED:**

NAME: Arrowhead Regional Medical Center

NAME: Ballard Rehabilitation Hospital

ADDRESS: 400 N Pepper Ave, Colton, CA 92324

ADDRESS: 1760 W 16th St, San Bernardino, CA 92411

TELEPHONE: ( ) (909) 580-1000

TELEPHONE: ( ) (909) 473-1200

DATE: June 17, 2024 TIME:  AM  PM

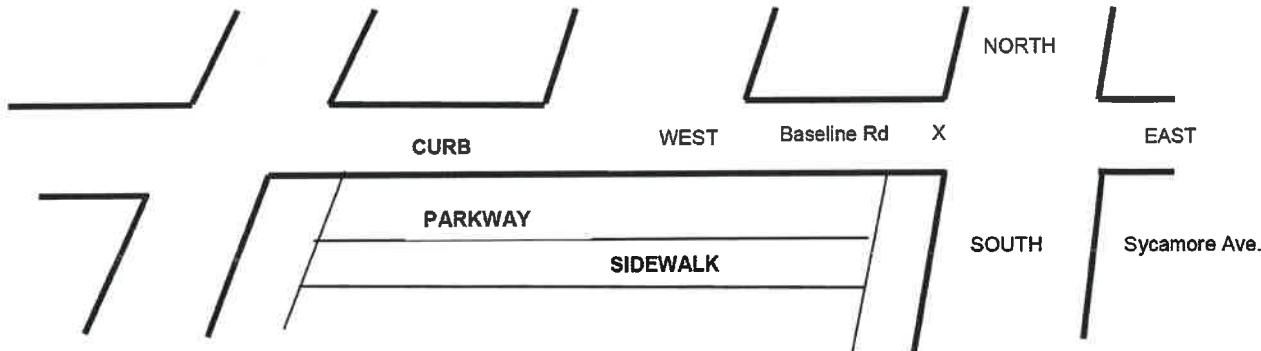
DATE: July 9, 2024 TIME:  AM  PM

**9. PLEASE READ THE FOLLOWING CAREFULLY:**

For all vehicle accident claims, place on the following diagram, the names of streets, including NORTH, EAST, SOUTH AND WEST directions. Indicate place of accident by "X" and by showing house numbers or distances to street corners.

If a city/town vehicle was involved, designate by letter "A" location of the City/Town vehicle when you first saw it, and by "B" location of yourself or your vehicle when you first saw City/Town vehicle; location of City/Town vehicle at time of accident by "A-1" and location of yourself or your vehicle at the time of the accident by "B-1" and the point of impact by "X".

⇒ **NOTE: IF THE DIAGRAM BELOW DOES NOT FIT THE SITUATION, PLEASE ATTACH A PROPER DIAGRAM SIGNED BY THE CLAIMANT.**



I HAVE READ THE FOREGOING CLAIM AND KNOW THE CONTENTS THEREOF; AND CERTIFY THAT THE SAME IS TRUE OF MY OWN KNOWLEDGE EXCEPT AS TO THOSE MATTERS WHICH ARE HEREIN STATED UPON MY INFORMATION AND BELIEF; AND AS TO THOSE MATTERS I BELIEVE THEM TO BE TRUE.

I CERTIFY (OR DECLARE) UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

SIGNATURE OF CLAIMANT OR AGENT

Thomas J. Conroy, Esq.

11/26/2024

TYPE OR PRINT NAME

DATE

Attorney of Behalf of Claimant

RELATIONSHIP TO CLAIMANT

NOTE: PRESENTATION OF A FALSE CLAIM IS A FELONY (CA PENAL CODE 72)  
RETURN CLAIM TO: RIALTO CITY CLERK'S OFFICE – 150 S. PALM AVE., RIALTO, CA 92376

