

Amended PM 2/17/2026

ROSE

# LIABILITY CLAIM FORM

RETURN SIGNED CLAIM FORM TO:

Clerk of the Board  
County of El Dorado  
330 Fair Lane  
Placerville, CA 95667



EDC BOS RCD  
FEB 17 '26 AM 11:15

DO NOT WRITE IN THIS SPACE  
(BOARD OF SUPERVISOR'S DATE STAMP)

Name of Claimant: <i>Sandra Rose</i>	Claimant's Mailing Address: [REDACTED]
Email: [REDACTED]	Claimant's Physical Address: (If different than mailing)  <i>Same</i>
Telephone (Home): [REDACTED]	
Telephone (Work/Cell): [REDACTED]	
*Social Security Number: [REDACTED]	
*Claimant's Date of Birth: [REDACTED] *Gender: <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
Driver's License Number: [REDACTED]	

\*If any portion of your claim is for bodily injury, this information is required to comply with Federal Medicare Reporting Requirements. Settlement will be delayed or prevented without this information.

Where would you like notices sent? (Include name and address if Attorney, Insurance Company or Other)

- Claimant
- Attorney
- Insurance
- Other

When did Damage or Injury occur?

DATE: *Aug. 25, 2025* TIME: *4:30*  AM  PM

Where did Damage or Injury occur?

*Henninson Lotus Park Baseball Field*

How did Damage or Injury occur? (Give full details - use extra sheet if necessary)

*I fell from uneven sidewalk at Lotus Baseball field. I fell hard onto cement sidewalk, injuring my left knee. Twisted low back and neck. The sidewalk was 2 inches uneven. (Photos were sent previously)*

What particular act or omission on the part of El Dorado County employees caused the Injury or Damage?

*Parks and trails is responsible for uneven sidewalks*

The County will report any payment made on this claim on an IRS form 1099-MISC. No payment will be made without the information furnished on the attached Payee Data Record. Disposition of the claim will rely solely on its merits and the furnishing of any form or other information will not ensure payment.

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What is the name of the El Dorado County employee who caused the Injury or Damage?

Parks and Trails / Parks and Rec.

What Damage or Injury do you claim resulted?

Injury to Left Knee.  
Torn meniscus, Bone contusion, Fluid, Inflammation.  
Permanent Scar.  
Surgery more than likely.

Amount of this claim is:

Under \$10,000

\$10,000-\$25,000

Over \$25,000

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If the amount you are claiming is under \$10,000, state the amount of the claim, including the estimated amount of any prospective injury, damage, or loss, as it may be known at this time. (Explain your calculation and attach bills or documents.)

- 1. will need possible Knee Surgery
- 2. Pain and Suffering
- 3. Future Lost wages

Other Details?

IF I will need Surgery, I would have to close my Daycare, which means I will lose my clients and would have to start over.

Names and Addresses of Witnesses, Doctors and/or Hospitals:

[Redacted]

[Redacted]

Claimant's Signature:

*[Handwritten Signature]*

Date:

2/10/26

Take Notice:

Section 72 of the Penal Code provides:

"Every person who, with intent to defraud, presents for allowance or for payment to any state board or officer, or to any county, city, or district board or officer, authorized to allow or pay the same if genuine, any false or fraudulent claim, bill, account, voucher, or writing, is punishable... as a felony."



# County of El Dorado

## OFFICE OF AUDITOR-CONTROLLER

**JOE HARN, CPA**  
Auditor-Controller

**TSUNG-KUEI HSU**  
Assistant Auditor-Controller

360 FAIR LANE  
PLACERVILLE, CALIFORNIA 95667  
Phone: (530) 621-5487 FAX: (530) 295-2535

### PAYEE DATA RECORD

(Required in lieu of IRS W-9 when receiving payment from the County of El Dorado) Version: April 2014

<b>PAYEE DATA RECORD</b>	<b>INSTRUCTIONS:</b> Complete all information on this form. Sign, date, and return to the address shown at the bottom of this page. Prompt return of the <b>fully completed</b> form will prevent delays in processing payments. Information provided in this form will be used by the County of El Dorado to prepare Information Returns (Forms 1099), for withholding on payments to nonresident payees, and for reporting to the Employment Development Department (EDD).				
<b>NAME AND ADDRESS</b>	Name (as shown on your income tax return) <i>Sandra Jean Rose</i>				
	Name, if different from above				
	Physical address (street, city, and state or ZIP)			Remittance address (if different than physical)	
	City, state, zip code			Phone number	
			Fax number (optional)		Email (optional)
<b>FEDERAL TAX CLASSIFICATION &amp; EXEMPTIONS</b>	<b>Check appropriate federal tax classification</b> <input checked="" type="radio"/> Individual / sole proprietor <input type="radio"/> Partnership <input type="radio"/> Trust / estate <input type="radio"/> Other (see instructions) ▶ _____ <input type="radio"/> C Corporation <input type="radio"/> S Corporation              If you are a corporation, do you provide legal or medical services? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Limited liability company. Enter the tax classification (C=C Corporation, S=S Corporation, P=Partnership) _____				
	<b>NOTE: IF YOU ARE A SINGLE MEMBER LLC (DISREGARDED ENTITY), ENTER THE TAX CLASSIFICATION OF THE OWNER IDENTIFIED ON THE NAME LINE.</b>				
	Exempt payee code (if any) – see instructions _____              Exemption from FATCA reporting code (if any) – see instructions _____				
<b>TAX IDENTIFICATION NUMBER</b>	Tax identification number (TIN)				
	Enter your TIN in the appropriate box. If you are an individual or sole proprietor, you must enter your SSN. You may choose to provide your EIN in addition to, but not instead of, the SSN. Single member LLCs (disregarded entities) must enter the TIN of the owner identified on the Name line.				
<b>RESIDENCY STATUS</b>	<b>Check appropriate box for residency status</b> <input checked="" type="radio"/> California resident / exempt from nonresident withholding – qualified to do business in California or maintains a permanent place of business in California (attach CA Form 590) <input type="radio"/> California nonresident (see instructions)				
	<b>NOTE:</b> Payments to California <b>nonresidents</b> for services performed in California and for certain rents derived from properties located in California that exceed \$1,500 in a calendar year will be subject to 7% nonresident withholding unless you have obtained a waiver or have been approved for reduced withholding by the Franchise Tax Board. There is no withholding on payments for product and for services performed outside of California.				
	<input type="checkbox"/> Obtained Franchise Tax Board waiver of State withholding (attach a copy if applicable) <input type="checkbox"/> Obtained Franchise Tax Board approval for reduced withholding (attach a copy if applicable)				
California sales tax permit number					
(required only for California nonresident vendors that charge California sales tax)					
<b>CERTIFICATION</b>	<b>Under penalties of perjury, I certify that:</b> 1) the TIN shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and 2) I am not subject to backup withholding and 3) I am a U.S. citizen or other U.S. person and 4) the FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.				
	Authorized Payee Representative's Name (Type or Print)			Title	
	<i>Sandra Jean Rose</i>			<i>owner</i>	
	Signature		Date	Telephone	
<i>Sandra Jean Rose</i>		<i>2/10/26</i>	[REDACTED]		
Should my residency status or any other information provided above change, I will promptly notify County of El Dorado at the address listed above.					
<b>RETURN FORM TO</b>	Please return completed form to:				
	Department/office:				
	Mailing address:				
	Phone:	Fax:	Email:		

SACRAMENTO CA 957

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FEB 17 26 #1

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County of EL Dorado  
330 Fair Lane  
Placerville CA 95667

95667-410390

