Taxis, Access & Mobility Services Division

CLAIM FOR REFUND FORM

Claimant makes this claim for refund of money paid to the City and County of San Francisco Municipal Transportation Agency (SFMTA)

First and Last Name (Please Print):

Address (No P.O Box): _____

Street Apt#/Unit#

City State Zip

Purpose of Payment:

☐ Citation Payment

☐ Other _____

_____

Amount paid: $_____

Date Paid: _____

Receipt #:_____

Please attach copy of receipt or any other proof of payment

Refund is requested for the following reasons:

☐ Duplicate payment

☐ Payment in excess of amount due

☐ Citation rescind

☐ Other: _____

This claim is filed within ONE YEAR after the last item of the account or claim has accrued with the head of the Department, Board or Commission originally receiving the money and the amount claimed is justly due.

I DECLARE (OR AFFIRM) UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT.

Signed by: _____ Date: _____

For internal office use

Director's Signature	Date

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