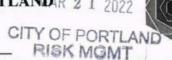


GENERAL LIABILITY

CLAIM AGAINST THE CITY OF PORTLANDAR 2 1 2022

* for damages to persons or property *

2022-012085-20 File Number:



RECEIVED

A claim must be filed with City of Portland Risk Management within 180 days after the occurrence of the incident or event.

Normal business hours: Monday through Friday, 8:00am to 5:00pm. Closed on official holidays.

Claims received during regular business hours will be recorded on the date received.

Faxed or emailed claims received after business hours will be recorded on the next working day.

Please be sure your claim is against the City of Portland, not another public entity.

Where space is insufficient, please use additional paper and identify information by section number and letter. Completed forms may be mailed, emailed, faxed, or hand-delivered to:

Risk Management/Liability, 1120 S.W. Fifth, Room 106/1040, Portland, OR 97204-1912, Ph: 503-823-5101, Fax: 503-823-6120

LiabilityClaims@portlandoregon.gov Date of Birth 1. Claimant (Circle: Mr. Mrs. Ms. Miss) a. Address (4117) S.F. Jennie La City Milwau Kiestate OF Zip 9726 b. Home Phone 503/1934420 Business Telephone 503 435 5990 Cell Phone 508 320 c. Occupation (Inti Que dealer d. Marital Status: Single () Married () Divorced or Widowed () If married, name of spouse d. E-mail address 2. If claim involves a vehicle: a. Year, make and model 2017 CLS 550 Mercedos Driver's License Number State OF b. License Plate Number Passenger N/A c. At time of accident, were you (check all that apply) Owner/ Driver d. Name and address of owner if different from claimant (1. Above) 3. Occurrence or event from which the claim arises: a. Date 3/5 b. Place (exact and specific location) c. Specify the particular occurrence, event, act, or omission by the City that you believe caused the injury or damage (use additional paper if necessary): d. State how the City of Portland or its employees were at fault: attoma Yes __ No _ OUST got OFF WORK e. Were you on the job at the time of the accident?

We are required to report all claims for injuri	es to Medicare/Medicaid Services	
If you were injured please provide the following:		
Medicare/Medicaid Beneficiary? Yes No _		
Give the name(s) of the City employee(s) and/o	or City Bureau causing the damage or injur	
motheman Ct	. 1 .	
Name and address of any other person injured	NA	
Name and address of the owner of any damage	d property if different from claimant	
Damages claimed:		
a. Amount claimed as of this date:	\$ 1599.86	1
b. Estimated amount of future costs:	\$	
c. Total amount claimed:	\$ 1599.86	
see bill of repair	1.	
Names, addresses / phone #s of all witnesses _	D/A	
Any additional information that might be help	ful in considering your claim	
Several Loworkers th	e next day viewed	the
hole and concored is	r was a disaster	
The William Control of the second		In Paris
NING: IT IS A CRIMINAL OFFENSE TO FILE A FALS		
	cluding any attached sheets, and I know them to be	
		CONTRACTOR OF STREET
vledge, except as to those matters stated upon informations and acknowledge that all statements made in the statements are in connection with an application for	his claim are made to a public servant of the City	of Portlan