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GENERAL LIABILITY CLAIM AGAINST THE CITY OF PORTLAND

* for damages to persons or property *

2023-013190-20 File Number:



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 90am to 5 90pm. 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, fixed, or hand-delivered to: Risk Management Liability, 1120 S.W. 5th Ave., Suite 1040, Portland, OR 97204-1912, Ph. 503-823-5101, Fax: 503-823-6120 LiabilityClaims@portlandoregon.gov

1. Cla	imant (Circle: Mr. Mrs Ms. Miss)	Pilar Gonzalez	Date of Birth	
4	Address 3046 SE Solman	City Partland	State OR Zip	77214
ь.	Home Phone 503 239 0262		Cell Phone 503-4	
c. (Occupation (Chical	d. Marital Status: Single () Marri	ied (TDivorced or Wid	owed()
	If married, name of spouse Vi	other Companies		
d.	E-mail address			
2. If cl	laim involves a vehicle: a. Ye	ar, make and model		Total Control of the
ъ.	License Plate Number	Driver's License Number		State
c. /	At time of accident, were you (check all that apply) Owner:Dri	ver Passenger _	N/A
		different from claimant (1 Above)		
3. Occ	urrence or event from which	the claim arises:	None and a second	
a. D	Date 1/6/13 - 1/13/13, nohip	dwales 1/9 Time	Circle_AM / J	PM PM
b. P	lace (exact and specific locati	on) Pesidonie @ 3046 SE Salm	un; roums imp	ured
	are my living and dinin	, rom com (cost side) walls	Icelling.	
c. Si	pecify the particular occurrence	e, event, act, or omission by the City	that you believe cause	ed the injury or
		necessary): While the city was a		
	no jurk Homenin of the	cement caused my name to sh	ake immension as	migh
1	e contrarate was active	ring and cooks in my wells ap	sound. As the in	L hamsung
	Production of the Control of the Con			
_6	continued, the cracks gen	r its employees were at fault: _crack	ex were not on m	undk/ceiter
d. Sta	te how the City of Portland o	r its emproyees were at faunt. Strate	I calle to He che	Aug best
2	w to the why completely	y sewer mork. I want at an	w space to the care	at mal boom
as	king truin to stop beco	where damage was gette	if marse , had the	we in to see the
e. We	ere you on the job at the time	of the accident? YesNo	damage	+ work resume
	es what is the name / phone		MAN CONTRACTOR OF THE PARTY OF	

City of Portland Risk Management 1/16/2023

If you were injured please provide the following: Social Socurity #:	A to report all claims for inturies to Medicare/Medicald Services* Coscilion and please provide the following: Social Security #:	4. Description: Describe the injury, property damage or loss so far as is known at the time of this claim.			
**Sextra required to report all claims for injuries to Medicare/Medicaid Services* If you were injured please provide the following: Social Security #: Medicare/Medicaid Beneficiary? Yes No Give the name(s) of the City employee(s) and/or City Bureau causing the damage or injury Name and address of any other person injured Name and address of the owner of any damaged property if different from claimant Damages claimed: a. Amount claimed as of this date: b. Estimated amount of future costs: c. Total amount claimed: b. Basis for computation of amounts claimed (include copies of all bills, invoices, estimates, etc.): Names, addresses/phone #s of all witnesses Names, addresses/phone #s of all witnesses Any additional information that might be helpful in considering your claim Length IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM! (ORS 162.085) Carefully read the statements made in this claim, including any attached sheets, and I know them to be true of carefully read the statements made in this claim, including any attached sheets, and I know them to be true of carefully read the statements made in this claim are made to a public servant of the City of Portland.	A to report all claims for inturies to Medicare/Medicald Services* Coscilion and please provide the following: Social Security #:	multiple crades along the walls in m	m living / dhing room + along the		
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Medicare/Medicaid Beneficiary? Yes No Give the name(s) of the City employee(s) and/or City Bureau causing the damage or injury Name and address of any other person injured Name and address of the owner of any damaged property if different from claimant Damages claimed: a. Amount claimed as of this date: b. Estimated amount of future costs: c. Estimated amount elaimed: b. Basis for computation of amounts claimed (include copies of all bills, invoices, estimates, etc.): cames, addresses / phone #s of all witnesses Any additional information that might be helpful in considering your claim ing: It is a Creminal Offense To File a False Claim! (ORS 162.085) carefully read the statements made in this claim, including any attached sheets, and I know them to be true of carefully read the statements made in this claim are made to a public servant of the City of Port and and acknowledge that all statements made in this claim are made to a public servant of the City of Port and and acknowledge that all statements made in this claim are made to a public servant of the City of Port and and acknowledge that all statements made in this claim are made to a public servant of the City of Port and and acknowledge that all statements made in this claim are made to a public servant of the City of Port and and acknowledge that all statements made in this claim are made to a public servant of the City of Port and and acknowledge that all statements made in this claim are made to a public servant of the City of Port and the Ci	of the City employee(s) and/or City Bureau causing the damage or injury ss of any other person injured ss of the owner of any damaged property if different from claimant t: d as of this date:				
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