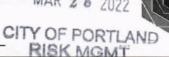


## GENERAL LIABILITY

CLAIM AGAINST THE CITY OF PORTLAND AR 2 8 2022

\* for damages to persons or property \*

2022-012106-28 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 6404 SE 23 Ave City Partland State OR Zip 977202 b. Home Phone \_\_\_\_\_\_ Business Telephone \_\_\_\_\_ Cell Phone 503 449 6162 c. Occupation \_\_\_\_\_\_ d. Marital Status: Single (v) Married ( ) Divorced or Widowed ( ) If married, name of spouse \_\_\_\_\_ d. E-mail address 2. If claim involves a vehicle: a. Year, make and model \_\_\_\_\_ b. License Plate Number Driver's License Number State c. At time of accident, were you (check all that apply) Owner: V Driver Passenger N/A d. Name and address of owner if different from claimant (1. Above) 3. Occurrence or event from which the claim arises: Time Circle AM / PM 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: the e. Were you on the job at the time of the accident? Yes \_\_\_\_\_(No) If yes, what is the name / phone number of employer

4.	Description: Describe the injury, property damage or loss so far as is known at the time of this claim.
-	#W/
5.	
	If you were injured please provide the following: Social Security #:
	Medicare/Medicaid Beneficiary? Yes(No)
5.	Sive the name(s) of the City employee(s) and/or City Bureau causing the damage or injury
7.	Name and address of any other person injured
8.	Name and address of the owner of any damaged property if different from claimant
9.	Damages claimed:
	a. Amount claimed as of this date: \$
	b. Estimated amount of future costs:  c. Total amount claimed:  \$ 45.00
	c. Total amount claimed:
	d. Basis for computation of amounts claimed (include copies of all bills, invoices, estimates, etc.):
0.	Names, addresses / phone #s of all witnesses
1.	Any additional information that might be helpful in considering your claim
V A	RNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM! (ORS 162.085)
I h kno	ave carefully read the statements made in this claim, including any attached sheets, and I know them to be true of my or owledge, except as to those matters stated upon information or belief and to such matters I believe the same to be true derstand and acknowledge that all statements made in this claim are made to a public servant of the City of Portland, at the statements are in connection with an application for a benefit from the City of Portland.
D	ate:  Doris Sharm
6	This sure of the s