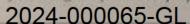


File Number:_

GENERAL LIABILITY CLAIM AGAINST THE CITY OF PORTLAND

· for damages to persons or property ·





A claim must be filed with City of Portland Risk Management within 180 days ofter the occurrence of the incident or event. Normal business hours: Monday through Finday, 8 00sm 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 were 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. 5th Ave., Suite 1040, Portland, OR 97204-1912, Ph. 503-823-5105, Fax: 503-823-6120 Liability Claims & portlandoregos, gov-

2	Address 2535 NW Lorenz St City CAMAS State WA Zip 98607
b.	Home Phone Business Telephone Cell Phone Soq 290 2/82
c.	Occupation Respiratory Thursday d. Marital Status: Single () Married Divorced or Widowed () If married, name of spouse Jenny Over
	E-mail address
. If	claim involves a vehicle: a. Year, make and model 2023 Ics I. Model V
	License Plate Number
c.	At time of accident, were you (check all that apply) Owner: X Driver X Passenger N/A
	Name and address of owner if different from claimant (1. Above)
2	Date 10/24/24 Time 07:20 Circle AM PM
b. Louis	Place (exact and specific location) 2027 Sw 6th Ave. 45.50860°N, 122.68423°W
	Specify the particular occurrence, event, act, or omission by the City that you believe caused the injury or
	damage (use additional paper if necessary): Hit pothele in unlit area of S
	It was after dark and I couldn't have seen or avoid
+	his massive crater. It resulted in \$1,130 in damage
10	to my EV
	State how the City of Portland or its employees were at fault: Extremely (were pothely in a high traffic unlit roadway

7.	5. *We are 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 dama	aged property if different from claimant		
	Damages claimed:	* 406.11		
1	a. Amount claimed as of this date:	\$ \$ 1,121.93		
	b. Estimated amount of future costs:	\$ \$ 17.28.04		
	c. Total amount claimed:	(include copies of all bills, invoices, estimates, etc.):		
	Names, addresses / phone #s of all witnesses	es		
-				
1	Any additional information that might be h	nelpful in considering your claim		
1	Any additional information that might be h	nelpful in considering your claim		
1	Any additional information that might be h	nelpful in considering your claim		
1	Any additional information that might be h	helpful in considering your claim		
	Any additional information that might be h			