



AUTO LIABILITY CLAIM AGAINST THE CITY OF PORTLAND

* for auto accidents involving a City vehicle *

2025000267GL

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, 8:00am 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 709, Portland, OR 97204-1912, Ph: 503-823-5101, Fax: 503-865-3297

LiabilityClaims@portlandoregon.gov

1. Claimant (Circle Mr.) Mrs. Ms. Miss) Joseph Copeland Date of Birth [REDACTED]
 a. Address 2712 SW Patton Court City Portland State OR Zip 97201
 b. Home Phone 503-422-0096 Business Telephone _____ Cell Phone 503-422-0096
 c. Occupation Attorney d. Marital Status: Single () Married (X) Divorced / Widowed ()
 If married, name of spouse Mims Copeland
 d. E-mail address [REDACTED]

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 _____ Driver _____ Passenger _____ N/A _____
 d. Name and address of owner if different from claimant: (1. Above) _____

 e. Name & address of driver if different from claimant: (1. Above) _____
 Phone number of Driver _____ Date of Birth of Driver _____
 f. Names / addresses / phone #'s of all occupants of vehicle at the time of the incident _____

3. Insurance: a. What company insures the damaged vehicle? _____
 b. Policy Number _____ Claim Number: _____
 c. Name and address of your insurance agent or adjuster _____
 _____ Type of Coverage _____

4. Occurrence or event from which the claim arises:
 a. Date of incident 01/14/2025 b. Exact location 2712 SW Patton Court, Portland, OR 97201
 c. Were you injured? Yes _____ No X Was anyone else injured? Yes _____ No X
 (If there was no injury, please state "No Injuries") _____
 d. Nature and extent of any injuries _____

e. If you were injured, name / phone / address of your treating doctor _____

f. ***We are required to report all claims for injuries to Medicare/Medicaid Services ***

If you were injured please provide the following: Social Security #: _____

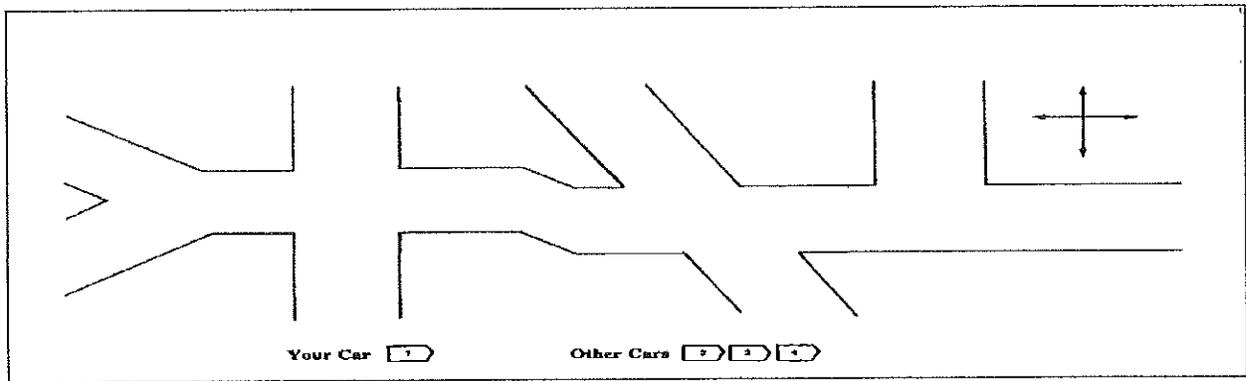
Medicare/Medicaid Beneficiary? Yes ___ No ___

g. Were you on the job at the time of the incident? Yes ___ No ___

If yes, what is the name / phone / address of your employer? _____

h. Name of City of Portland Driver Unknown City vehicle license# _____

Names / Addresses / Phone Numbers of any witnesses to the incident: Roman Garcia 971-501-0731



5. **Description of Incident:** What happened? Give a full account, including the speed of each car and the direction each car was traveling. Please use the diagram above.

PBOT vehicle rolled down street and damaged fence and exterior portion of neighbor's garage. Neighbors are Stuart and Marcia Weiss.

6. **Damages claimed:**

- a. Amount claimed as of this date Don't know repair costs yet
- b. Estimated amount of future costs _____
- c. Total amount claimed _____

WARNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM! (ORS 162.085)

I have carefully read the statements made in this claim, including any attached sheets, and they are true. I understand and acknowledge that all statements made in this claim are made to a public servant of the City of Portland, and that the statements are in connection with an application for a benefit from the City of Portland.

1-15-2025
DATE

[Signature]
CLAIMANT'S SIGNATURE

