SS PLOP

AUTO LIABILITY
CLAIM AGAINST THE CITY OF PORTLAND
** for auto accidents involving a City vehicle **

File Number: 2025000383AL

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) Kyra Child Date of Birth [redacted]

a. Address 2630 NW Garryanna St City Corvallis State OR Zip 97330

b. Home Phone — Business Telephone — Cell Phone 503-543-6102

c. Occupation Loss Prevention d. Marital Status: Single (X) Married ( ) Divorced / Widowed ( )

If married, name of spouse

d. E-mail address [redacted]

2. If claim involves a vehicle: a. Year, make and model 2016 Honda Dilbt

b. License Plate Numbe [redacted] Driver's License Number [redacted] State OR

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 ~~2024788406~~ 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? Direct Auto Insurance

b. Policy Numbe [redacted] Claim Number [redacted]

c. Name and address of your insurance agent or adjuster Norma Fabela
PO Box 1623 Winston, Salem NC 27102 Type of Coverage full

4. Occurrence or event from which the claim arises:

a. Date of incident 02/06/2025 b. Exact location Highway 205 exit 17

c. Were you injured? Yes ___ No X Was anyone else injured? Yes ___ No X

(If there was no injury, please state "No Injuries") No injuries

d. Nature and extent of any injuries No injuries

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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 _____

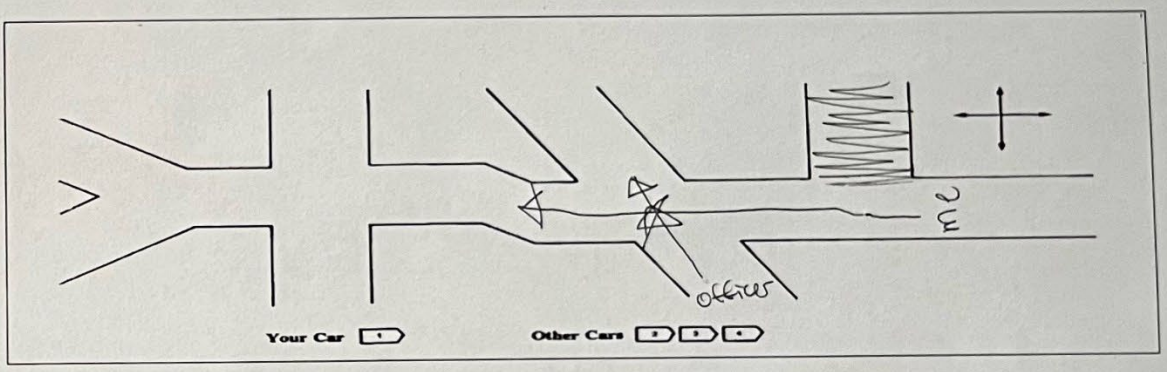
If yes, what is the name / phone / address of your employer? _____

_____

h. Name of City of Portland Driver_____ City vehicle license# _____

Names / Addresses / Phone Numbers of any witnesses to the incident: _____

PD Case Number: 25-33240



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.

I was taking exit 17 off of 205 at about 45 MPH. My light was green and I didn't hear or see anything unusual so I continued. The officer turned on his lights just before we collided in the inter section.

6. **Damages claimed:**

a. Amount claimed as of this date _____

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.

02/12/2025
DATE

CLAIMANT'S SIGNATURE

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