



AUTO LIABILITY CLAIM AGAINST THE CITY OF PORTLAND

* for auto accidents involving a City vehicle *

2025000975AL

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. 5th Ave., Suite 1040, Portland, OR 97204-1912, Ph: 503-823-5101,

Fax: 503-823-6120, email: LiabilityClaims@portlandoregon.gov

1. **Claimant** (Circle: Mr. Mrs. Ms. Miss) Aimee Battige Date of Birth [REDACTED]
 - a. Address 1818 SE Mulberry Ave City Portland State OR Zip 97214
 - b. Home Phone N/A Business Telephone N/A Cell Phone 503-816-9694
 - c. Occupation _____ d. Marital Status: Single () Married () Divorced () Widowed ()
 - If married, name of spouse Yantiff Shaykin
 - d. E-mail address [REDACTED]
2. **If claim involves a vehicle:** a. Year, make and model Toyota Camry
 - 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 4-17-2025 b. Exact location _____
 - 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 Passenger side rear back panel damage caused by city vehicle. City employee left insurance card on dash window under windshield wiper. See pictures for details.

e. If you were injured, name / phone / address of your treating doctor N/A
only damage to vehicle

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

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

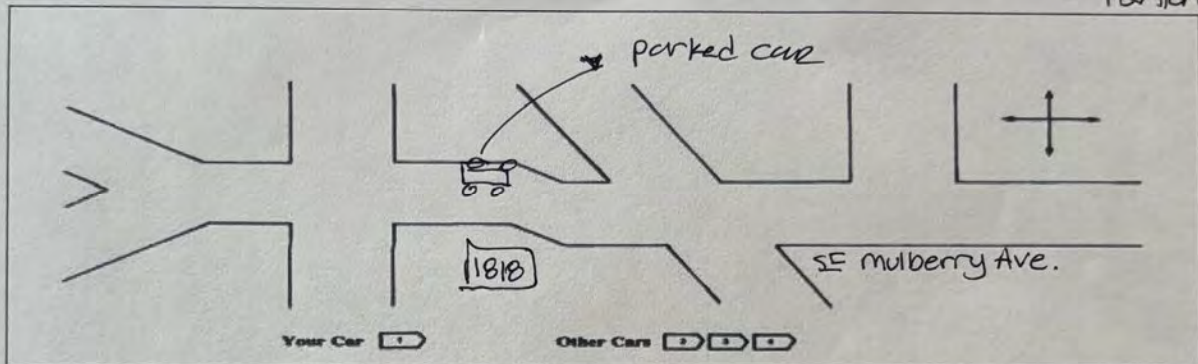
Medicare/Medicaid Beneficiary? Yes _____ No _____

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

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

h. Name of City of Portland Driver ? City vehicle license# ?

Names / Addresses / Phone Numbers of any witnesses to the incident: City employee Left
card on windshield (no name or license#), card = Risk mgmt info for
Portland



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.

Camry was parked across
the street from our house (1818 SE Mulberry) facing
North / towards 12th

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.

4/25/25
 DATE

[Signature]
 CLAIMANT'S SIGNATURE





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CLAIM AGAINST THE CITY OF PORTLAND**

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City of Portland Risk Management 7/2/2025

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

only damage to vehicle

f. **We are required to report all claims for injuries to persons or property.**

If you were injured please provide the following information: _____