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MFSA

AUTO LIABILITY

CLAIM AGAINST THE CITY OF PORTLAND

** for auto accidents involving a City vehicle **

File Number: 2025001126AL

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: 503-823-6120
LiabilityClaims@portlandoregon.gov

1. **Claimant** (Circle: Mr. Mrs. Ms. Miss) Adam chase daugherty Date of Birth [redacted]
   a. Address 11633 E Burnside St City Portland State OR Zip 97216
   b. Home Phone _____ Business Telephone _____ Cell Phone 541-390-8445
   c. Occupation flooring installer d. Marital Status: Single (✓) Married ( ) Divorced / Widowed ( )
   If married, name of spouse _____
   d. E-mail address [redacted]
2. **If claim involves a vehicle:** a. Year, make and model 1999 Dodge Dakota sport
   b. License Plate Number [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 _____ 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? Dairyland insurance
   b. Policy Number [redacted] Claim Number: _____
   c. Name and address of your insurance agent or adjuster 1800 North Point Dr, Stevens Point, WI Type of Coverage liability
4. **Occurrence or event from which the claim arises:**
   a. Date of incident Aug, 12, 2025 b. Exact location 99th Ave glisan East bound
   c. Were you injured? Yes ___ No ✓ Was anyone else injured? Yes ___ No ✓
   (If there was no injury, please state "No Injuries") 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 ✓

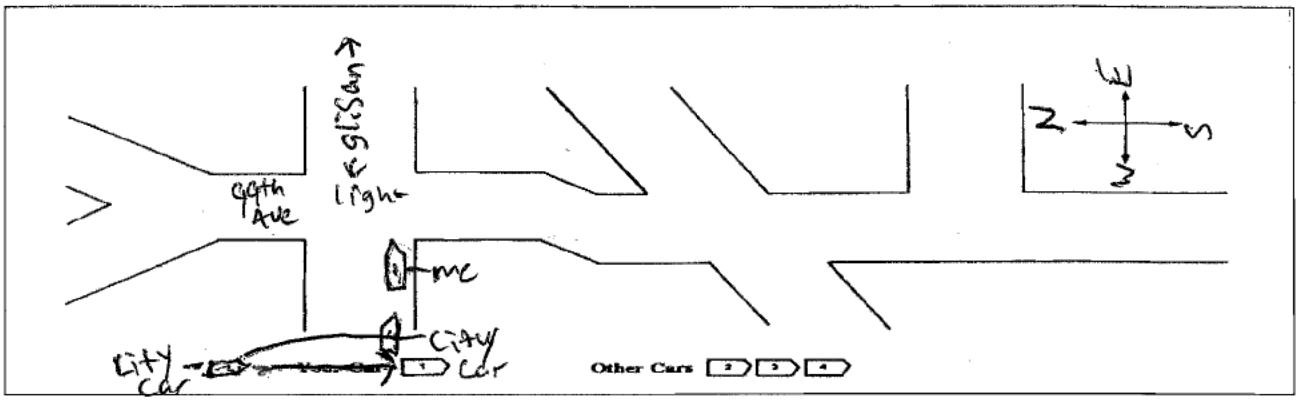
If yes, what is the name / phone / address of your employer? _____

_____

h. Name of City of Portland Driver Nelson, trey Brown City vehicle license# E265827

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

_____



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.

Driving east Bound waiting for light to turn green, when (nelson trey Brown) Not Paying Attention Struck me going Around 10-15 miles per hour maybe less.

6. **Damages claimed:**

a. Amount claimed as of this date 2,350.00

b. Estimated amount of future costs N/A

c. Total amount claimed 2,350.00

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.

Aug, 18, 2025
DATE

CLAIMANT'S SIGNATURE