GENERAL LIABILITY
CLAIM AGAINST THE CITY OF PORTLAND

** for damages to persons or property **

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 LiabilityClaims@portlandoregon.gov

1. Claimant (Circle: Mr. Mrs. Ms. Miss)_____Date of Birth _____

a. Address_____City_____State_____Zip _____

b. Home Phone_____Business Telephone_____Cell Phone _____

c. Occupation_____d. Marital Status: Single ( ) Married ( ) Divorced or Widowed ( )

If married, name of spouse _____

d. E-mail address _____

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)_____

_____

3. Occurrence or event from which the claim arises:

a. Date_____Time_____ Circle AM / PM

b. Place (exact and specific location) _____

_____

c. Specify the particular occurrence, event, act, or omission by the City that you believe caused the injury or damage (use additional paper if necessary): _____

_____

_____

_____

d. State how the City of Portland or its employees were at fault: _____

_____

_____

e. Were you on the job at the time of the accident? Yes____No _____

If yes, what is the name / phone number of employer _____

4. **Description:** Describe the injury, property damage or loss so far as is known at the time of this claim. _____

_____

_____

5. ***<u>We are required to report all claims for injuries to Medicare/Medicaid Services</u>***

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

   Medicare/Medicaid Beneficiary? Yes____ No ___

6. **Give the name(s) of the City employee(s) and/or City Bureau causing the damage or injury** _____

_____

7. **Name and address of any other person injured** _____

_____

8. **Name and address of the owner of any damaged property if different from claimant** _____

_____

9. **Damages claimed:**

   a. Amount claimed as of this date: $ _____

   b. Estimated amount of future costs: $ _____

   c. Total amount claimed: $ _____

   d. Basis for computation of amounts claimed (include copies of all bills, invoices, estimates, etc.): _____

_____

_____

10. **Names, addresses / phone #s of all witnesses** _____

_____

_____

11. **Any additional information that might be helpful in considering your claim** _____

_____

_____

_____

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 I know them to be true of my own knowledge, except as to those matters stated upon information or belief and to such matters I believe the same to be 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.

Date: _____

_____ _____

Claimant's Signature Print Name