

OREGON STANDARD TORT CLAIM FORM

Claimant Information	1. Claimant name: _____ <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 5px;"> Last Name First Middle Date of Birth (mm/dd/yyyy) </div> 2. Current residential address: _____ 3. Mailing address (if different): _____ 4. Claimant's telephone number: Home _____ Alternate _____ 5. Claimant's email address: _____
Incident Information	6. Date of Incident: _____ Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. 7. Location of incident: _____ 8. Description of incident: 9. Police report? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please provide the report number and the police agency name (City, County or State) Report Number: _____ Police Agency Name: _____
State Agency	10. Name of State agency involved and why you believe they are responsible for your damage/injury. 11. Name of employee (if applicable): _____
Damages	12. If injuries occurred, please complete the bodily injury questionnaire. 13. If property damage occurred, describe it below and list and provide photographs and 2 estimates.
Witnesses	14. Witness name, address, phone number and relationship: _____ _____ _____

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Bodily Injury Questionnaire: IMPORTANT: We are required by federal law to obtain the information in questions 15 through 17. Failure to provide this information will result in delays in resolving your claim. You can find further information at [Centers for Medicare and Medicaid Services - Home Website.](#)

Bodily Injury Questionnaire	15. Last Name	First name	Middle initial
	16. Date of Birth (mm/dd/yyyy)	17. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
	18. Is this related to an auto accident? (If no, skip to question 22)		
	19. If yes, where were you seated in vehicle? <input type="checkbox"/> Driver <input type="checkbox"/> Front right passenger <input type="checkbox"/> Rear right passenger <input type="checkbox"/> Rear left passenger <input type="checkbox"/> Other _____		
	20. Seatbelt used? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind? <input type="checkbox"/> Lap <input type="checkbox"/> Shoulder <input type="checkbox"/> None		
	21. Did the airbag deploy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	22. Describe your injury:		
	23. When did you first notice you were injured?		
	24. Have you sought medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. If yes, list the medical providers you have seen:
	26. Approximate amount of medical costs incurred to date:		
	27. Is future treatment expected? <input type="checkbox"/> Yes <input type="checkbox"/> No		28. If yes, explain:
	29. Do you have any prior injuries to the injured body part(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No		30. If yes, explain:
	31. Any other information you would like to provide us:		

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Additional information:

Per ORS 30.275, Risk Management must receive your claim within 180 days from the date of loss.

I declare the foregoing is true and correct to the best of my knowledge.

Signature of claimant _____ Date _____

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EMAIL