DAS
DEPARTMENT OF ADMINISTRATIVE SERVICES

Risk Management | SSD
1225 Ferry Street SE, U150
Salem, OR 97301
503-373-7475
503-373-7337 fax

E-mail:
Website:
Find this form on the Web at:

OREGON STANDARD TORT CLAIM FORM

Claimant Information

Claimant information

1. Claimant name:_____

Last Name | First | Middle | Date of Birth (mm/dd/yyyy)

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:_____❑a.m. ❒ p.m.

7. If the incident occurred over a period of time, date of first and last occurrences:

8. Location of incident:

9. Description of incident:

10. Police report yes/no (check one). If yes, please provide the report number and the police agency name (City, County or State)

Report Number: Police Agency Name:

State Agency

11. Name of State agency involved and why you believe they are responsible for your damage/injury.

12. Name of employee (if applicable):

Damages

13. If injuries occurred, please complete the bodily injury questionnaire.

14. If property damage occurred, describe it below and list and provide photographs and 2 estimates.

Witnesses

15. Witness name, address and phone number (Relationship)

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Bodily Injury Questionnaire: **IMPORTANT: We are required by federal law to obtain the information in questions 16 through 20. Failure to provide this information will result in delays in resolving your claim. You can find further information at .**

Bodily Injury Questionnaire

16. Last Name	First name / Middle initial
17. Date of Birth (mm/dd/yyyy)	18. Gender ❑M ❑F / 19. Social Security number
20. Are you a Medicare beneficiary? ❑Yes ❑No	21. If so, provide HICN (required by federal law)
22. Is this related to an auto accident? (If no, skip to question 26) ❑Yes ❑No	
23. If yes, where were you seated in vehicle? ❑Driver ❑Front right passenger ❑Rear right passenger ❑Rear left passenger ❑Other _____	
24. Seatbelt used? ❑Yes ❑No	What kind? ❑Lap ❑ Shoulder ❑ None
25. Did the airbag deploy? ❑Yes ❑ No	
26. Describe your injury:	
27. When did you first notice you were injured?	
28. Have you sought medical treatment? ❑Yes ❑No	29. If yes, list the medical providers you have seen:
30. Approximate amount of medical costs incurred to date:	
31. Is future treatment expected? ❑Yes ❑No	32. If yes, explain:
33. Do you have any prior injuries to the injured body part(s)? ❑Yes ❑No	34. If yes, explain:
35. Do you have any other health issues (such as diabetes, arthritis, etc)? ❑Yes ❑No	36. If yes, explain:
37. Any other information you would like to provide to 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 _____

PRINT EMAIL