DAS
DEPARTMENT OF ADMINISTRATIVE SERVICES

Risk Management | EGS
PO Box 12009
Salem, OR 97309-0009
503-373-7475
503-373-7337 fax

IMPORTANT: Must be completed in Acrobat Reader.

E-mail: risk.management@oregon.gov
Website: State of Oregon: Risk Management

Find this form on the Web at:
https://www.oregon.gov/das/Risk/Documents/Form_AllClaimsNonAuto.pdf

# OREGON STANDARD TORT CLAIM FORM

## 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. Location of incident: _____
8. Description of incident:
9. Police report? ☐ yes ☐ 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:



Revised 06/26/2018
Form No. DAS-RM Standard form

DAS
DEPARTMENT OF ADMINISTRATIVE SERVICES

Risk Management | EGS
PO Box 12009
Salem, OR 97309-0009
503-373-7475
503-373-7337 fax

E-mail: risk.management@oregon.gov
Website: State of Oregon: Risk Management

Find this form on the Web at:
https://www.oregon.gov/das/Risk/Documents/Form_AllClaimsNonAuto.pdf

# OREGON STANDARD TORT CLAIM FORM

**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 ☐M ☐F

18. Is this related to an auto accident? (If no, skip to question 22)

19. If yes, where were you seated in vehicle?

☐Driver ☐Front right passenger ☐Rear right passenger ☐Rear left passenger ☐Other _____

20. Seatbelt used? ☐Yes ☐No What kind? ☐Lap ☐Shoulder ☐None

21. Did the airbag deploy? ☐Yes ☐No

22. Describe your injury:

23. When did you first notice you were injured?

24. Have you sought medical treatment? ☐Yes ☐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? ☐Yes ☐No 28. If yes, explain:

29. Do you have any prior injuries to the injured body part(s)? ☐Yes ☐No 30. If yes, explain:

31. Any other information you would like to provide us:



Revised 06/26/2018
Form No. DAS-RM Standard form

DAS
DEPARTMENT OF ADMINISTRATIVE SERVICES

Risk Management | EGS
PO Box 12009
Salem, OR 97309-0009
503-373-7475
503-373-7337 fax

E-mail: risk.management@oregon.gov
Website: State of Oregon: Risk Management
Find this form on the Web at:
https://www.oregon.gov/das/Risk/Documents/Form_AllClaimsNonAuto.pdf

# OREGON STANDARD TORT CLAIM FORM

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 _____



Revised 06/26/2018
Form No. DAS-RM Standard form