

NOTICE OF TORT CLAIM

If you have sustained some type of damage and you believe that the damage was a result of the negligence of an officer or employee of the City of Stillwater, you may be entitled to recover all or a portion of your damages under the Oklahoma Governmental Tort Claims Act (51 Oklahoma Statutes, Section 151, et seq). In order to comply with this Act you must file a written claim with the City Clerk of the City of Stillwater. You do not need a lawyer to file a claim against the City of Stillwater. The City of Stillwater is self-insured. Please complete the form, print, sign, date and return to:

City of Stillwater
City Clerk
723 S. Lewis, P.O. Box 1449
Stillwater, Oklahoma 74076
Phone (405) 742-8243

Investigation or negotiation by the City of Stillwater, either before or after a denial, is not and should not be construed as an express or implied admission of liability, an assurance of settlement, or a waiver of any statute or limitation that may be adverse to your claim.

CLAIM NUMBER: _____

(For internal use)

NOTICE OF TORT CLAIM

CLAIMANT:

Name: (First, Middle, Last)

Address: (Street, City, State, Zip)

Phone: (Home, Mobile)

INCIDENT:

(Date, Time, Location, and Description of the Incident)

(Use Additional Page(s) if Necessary)

PROPERTY DAMAGE:

Did Claimant incur property damage? YES NO

Description of Property and Damage: _____

(Use Additional Page(s) if Necessary)

Please attach copies of title/proof of ownership, pictures of the damage, two repair estimates or actual receipts for completed repairs for all damaged property.

TOTAL CLAIM FOR PROPERTY DAMAGE \$ _____

PERSONAL INJURY:

Was Claimant Injured? YES NO

If you are seeking compensation for personal injury, you must complete the following statement. Failure to complete the statement will result in immediate denial of any claim for personal injury.

Pursuant to 42 U.S.C. § 1395 (Medicare Reporting Section 111) I state the following information is true and correct:

Social Security Number: _____; Date of Birth: _____;

Gender: () Male () Female (check one).

I further state that:

(check one) () I AM Medicare eligible and my HICN is _____.

() I AM NOT Medicare eligible.

Description of Injury: _____

(Use Additional Page(s) if Necessary)

Name/Address of Physician(s): _____

Please submit a copy of all medical bills and reports generated as a result of this incident.

TOTAL CLAIM FOR PERSONAL INJURY \$ _____

LIABILITY:

Please identify and describe the evidence that proves the City or a City employee caused the injury or damage to you or your property:

(Use Additional Page(s) if Necessary)

Please identify all witnesses known to you. (Use Additional Page(s) if Necessary)

Witness: (Name, Address, Phone Number)

Witness: (Name, Address, Phone Number)

Please state the exact amount of total compensation you would accept as full settlement of this claim.

TOTAL CLAIM \$ _____

I hereby swear or affirm that the claim information provided above and within is true and correct and that no part of this claim has been previously paid.

(Claimant's Signature)

(Date)