



PETITION TO THE TOWN COUNCIL

To the Honorable Town Council of the Town of Bristol:

The undersigned hereby respectfully request of your

Honorable Body that:

Melissa Cordeiro
Council Clerk

see attached

TOWN CLERK'S OFFICE
BRISTOL, RHODE ISLAND

2025 AUG 13 DATE RECEIVED

PLEASE NOTE:

Please ensure that your petition is submitted by 4:00 PM two (2) Wednesdays before the Town Council meeting scheduled for Aug 19th

In order to be included on the Town Council docket. According to Council policy, petitions cannot be addressed unless recommendations, if needed from the relevant departments are received before the Council meeting.

SIGNATURE: *Paula A. Armillo*

NAME: Paula A. Armillo #2

ADDRESS: 74 Charles St

TOWN: Bristol, RI 02809

☐ Email: _____

☐ Tel. Number _____

Non-Staff INCIDENT/ACCIDENT REPORT

Department:		Today's date: <u>8-13-2026</u>		
Name of Injured: <u>Paula A. Armillotto</u>	SSN: _____	Gender: <u>Female</u>	DOB: _____	Date of Injury: <u>6-10-2026</u>
Home Address: <u>74 Charles St</u>		Telephone: _____		
City: <u>Bristol</u>	State: <u>RT</u>	ZIP Code: <u>02809</u>		
Nature of injury & part of body: <u>Left side hip to ankle left lower leg cuts</u>				
Date of injury: <u>6-10-2026</u>		Time of injury: <u>12pm ?</u> <u>9 sprained</u>		
Date injury reported: <u>6-10-2026</u>		Time injury reported: <u>12pm ?</u>		
Location where the injury occurred: <u>Town transfer station</u>				
Describe how the injury occurred: <u>Fell through a large opening between to concrete retaining blocks.</u>				
Did rescue respond? Y ☒ N		Did PD investigate? Y ☒ N		
Have you been, or do you plan to see, a physician? Y ☒ N		Pre-existing condition? Y ☒ N		
Activity at Time of Injury (specific activity): <u>unloading back of truck & standing on stone</u>				
Were others present at time of the injury? (If yes, provide names and phone numbers.) <u>NO</u>				
Supervision at time of injury:				
Name and address of physician or hospital where seen for this injury? <u>Brown Medical / Newport Hospital</u>				
I attest that the above information has been accurately completed to the best of my knowledge. I also hereby request and authorize disclosure, whenever requested to do so by the Rhode Island Interlocal Risk Management Trust or its representatives, any and all information which concerns me with respect to illness or injury, medical history, consultation, diagnosis, prescription or treatment, including x-rays, and copies of all medical and/or hospital records. This is not a release of any claim that I may have.				
Print name: <u>Paula A. Armillotto</u>		Self / Parent / Legal guardian (please circle)		
Signature: <u>PA</u>		Date: <u>8-13-2026</u>		



PO BOX 1259 DEPT 182534 | OAKS, PA 19456

BILLING STATEMENT

Questions, concerns, or want to pay over the phone?

Call our billing line at **401-366-4329**

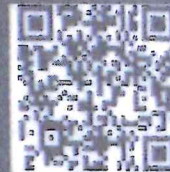
Monday - Friday 8:00am - 5:00pm

ADDRESSEE

PAULA A ARMILLOTTO
74 CHARLES STREET
BRISTOL, RI 02809

Online Bill Pay

Scan this QR code for a directlink to
make payment on your account
No login required



View all your billing information on **MyChart**

Visit mychart.brownhealth.org for details about your account,
payment plan options, and financial assistance programs.

Please make checks payable and send to:

Brown University Health
PO Box 411746
Boston, MA 02241-1746

Payment Due	Amount Due	Amount Enclosed
08/27/26	\$200.00	

STMT-70568952 Guarantor ID: 100160251

Guarantor Acct #: 10

Statement Date: August 06, 2026

The balance on this statement is now your responsibility. **There are accounts on this statement that are now past due.** Our records indicate that your insurance company has either paid or denied their portion of the bill. If you have questions about the insurance payment, please contact your insurance company. **Please remit payment in full by 08/27/26 or contact us at the phone number listed above to arrange payment.**

Balance Aging Summary

Current	30 Days	60 Days	90 Days	120+ Days	Total Balance
\$0.00	\$200.00	\$0.00	\$0.00	\$0.00	\$200.00

Date	Description	Charges	Pmts/Adjs	Patient Balance
Hospital Svcs: #3002488001 - Paula A Armilotto				
Emergency - Provider: Kyle Martin, DO				
Newport Hospital Emergency Department				
06/10/26	Emergency Room	1,494.00		
to	Medications	5.00		
06/11/26	Radiology - Diagnostic	643.00		
	Blue Cross Payments and Adjustments		-1,942.00	
	Copay: 200.00			
	Totals	2,142.00	-1,942.00	200.00
	Totals	2,142.00	-1,942.00	200.00
	Balance Due			200.00

Important Billing Information:

Please note that some services you received, including physician and other professional services, may be billed separately and may not be included on this statement. You may receive additional bills from other providers involved in your care.

Financial Assistance

If you are unable to pay this bill, you may be eligible for assistance through our Community Free Service Program. For eligibility information, please contact one of our financial advocates at the number below, or visit brownhealth.org/financial-assistance to apply.

The Miriam Hospital: 401-793-2206

Newport Hospital: 401-845-1490

All other locations: 401-444-7850

For all other billing questions, or to make payment, please call 401-366-4329.