TOWN OF BRISTOL
Settled 1680
Virtute et Industria
RHODE ISLAND

Melissa Cordeiro
Council Clerk

PETITION TO THE TOWN COUNCIL

RECEIVED
TOWN CLERK'S OFFICE
BRISTOL, RHODE ISLAND
2025 DEC 13 AM 8:46
DATE RECEIVED

To the Honorable Town Council of the Town of Bristol:

The undersigned hereby respectfully request of your Honorable Body that:

See attached

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: [signature]

NAME: Paula A. Hamilton

ADDRESS: 74 Charles St

TOWN: Bristol, RI 02809

☐ Email:

☐ Tel. Number

Non-Staff INCIDENT/ACCIDENT REPORT

Department:		**Today's date:** 8-13-2026		
Name of Injured: Paula A. Armillotta	**SSN:**	**Gender**	**DOB**	**Date of Injury**
		Female		6-10-2026

Home Address: 74 Charles St **Telephone:**

City: Bristol **State:** RI **ZIP Code:** 02809

Nature of injury & part of body: Left side hip to ankle. left lower leg cut/s & sprained

Date of injury: 6-10-2026 **Time of injury:** 12pm ?

Date injury reported: 6-10-2026 **Time injury reported:** 12pm ?

Location where the injury occurred: Town transfer station

Describe how the injury occurred: Fell through a large opening between to concrete retaining blocks.

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): ~~Unloading~~ Unloading back of truck & standing on stone between blocks.

Were others present at time of the injury? *(If yes, provide names and phone numbers.)*

NO

Supervision at time of injury:

Name and address of physician or hospital where seen for this injury?

Brown Medical / Newport Hospital

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: Paula A. Armillotta **Self / Parent / Legal guardian** *(please circle)*

Signature: PA **Date:** 8-13-2026

BROWNHealth
UNIVERSITY

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

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.

ADDRESSEE

PAULA A ARMILLOTTO
74 CHARLES STREET
BRISTOL, RI 02809

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 #: 1(

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	Patien Balance
Hospital Svcs: #3002488001 - Paula A Armillotto Emergency - Provider: Kyle Martin, DO Newport Hospital Emergency Department				**This account is 30 days past due**
06/10/26 to 06/11/26	Emergency Room	1,494.00		
	Medications	5.00		
	Radiology - Diagnostic	643.00		
	Blue Cross Payments and Adjustments Copay: 200.00		-1,942.00	
	Totals	**2,142.00**	**-1,942.00**	**200.0**
	Totals	**2,142.00**	**-1,942.00**	**200.0**
	Balance Due			**200.0**

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.