The City of
NORMAN

NOTICE OF TORT CLAIM

FILED IN THE OFFICE
OF THE CITY CLERK
ON 04/02/2025-LW

Return Completed Forms to:
City Clerk's Office – Tort Claims
CITY OF NORMAN, P.O. BOX 370
NORMAN, OKLAHOMA 73070

Please complete *ALL* pages of this form. Please print or type the responses. ***Failure to provide information required in this form can invalidate your claim.***

CLAIMANT(S) INFORMATION

CLAIMANT(S): ELLAINA PINKERTON Date of Birth: [redacted]

[redacted]

Claimants that are joint owners of property (such as co-owners of a vehicle or home) **must both** be included on the tort claim.

If Claimant is not the owner of the damaged property, provide owner's name, address, email, and daytime phone number.

CLAIM INFORMATION

DATE OF INCIDENT: 08/01/2024 TIME: 0900 ☑ a.m. ☐ p.m.

LOCATION OF INCIDENT: 112 W DAWS ST NORMAN, OK

STATEMENT OF CIRCUMSTANCES / REASONS YOU BELIEVE CITY IS LIABLE:
Include the name of the City department and/or employee involved. Provide any evidence that will prove City or a City employee was responsible, including any photographs of the alleged damages to support your claim.

City employees were working on the parking lot of the police department prior, to the scheduled date and time, causing damages to the paint, window, and taillights of my vehicle. They also caused similar damages to fellow employees' vehicles: David Grissam and Faith Richardson.

(Use additional pages if necessary.)

INSURANCE INFORMATION

List the name of your insurance company and agent, the address, and phone number.

Have you filed a claim with your insurance company for these damages? ☐Yes ☑No
If yes, submit a copy of your claim.

Have you been, or do you expect to be, compensated for your damages by your insurance company? ☐Yes ☑No

What was or will be the amount of compensation from your insurance company? $ _____

COMPENSATION REQUESTED

PROPERTY DAMAGE:

Please list items damaged, the age and original cost of each item, the amount of property loss claimed, and include any required supporting documentation referenced below.

PROPERTY DAMAGE DESCRIPTION:	AMOUNT CLAIMED:
1. POV CHIPPED PAINT, WINDOWS & LIGHTS	$ 11,704.65
2.	$
3.	$
4.	$
TOTAL AMOUNT CLAIMED FOR PROPERTY DAMAGE:	$ 11,704.65

Required Supporting Documentation for Property Damage:

1. If you are alleging damage to your vehicle:
   a. Copy of the vehicle title, front and back;
   b. Photographs of the vehicle showing the damage, including photographs of the VIN and License Plate;
   c. Copy of either actual repair bill OR two estimates for cost of repair; AND
   d. Copy of receipts or estimates showing associated expenses such as: towing, vehicle rental, etc.
2. If you are alleging damage to your home or to real property:
   a. Copy of the current deed.

OTHER DAMAGE (Is the claim seeking compensation other than for loss or damage to property?):

Please describe the type of injury or damage you sustained. You **must** state the compensation requested (do not include amounts already requested in previous sections) and include any required supporting documentation referenced below.

OTHER DAMAGE DESCRIPTION:	AMOUNT CLAIMED:
1. RENTAL VEHICLE	$ 8,600.48
2.	$
3.	$
4.	$

Were you on the job at the time of the injury? ☐Yes ☑No
If so, what is the name of your employer? N/A

Has any medical bill been paid or will be paid by Medicare/Medicaid? ☐Yes ☑No

If so, list: Medicare/Medicaid number: N/A SSN: N/A

Date of Birth: N/A Gender: N/A

If the City is responsible for such bills, the City must report any settlement to Medicare/Medicaid.

I understand that the information requested is to assist the requesting insurance information arrangement to accurately coordinate benefits with Medicare/Medicaid and to meet its mandatory reporting obligation under Medicare Secondary Payer Act 42 U.S.C§1395y.

Medicare/Medicaid Beneficiary Name (please print)

Medicare/Medicaid Beneficiary Name Signature

TOTAL AMOUNT OF OTHER DAMAGE CLAIMED: $ 8,600.48

Required Supporting Documentation for Other Damage:

1. If you are alleging personal injury:
   a. Name and address of all health care providers who provided treatment since the time of the incident, AND
   b. A HIPPA compliant authorization for release of health information from all providers.

TOTAL AMOUNT REQUESTED TO FULLY SETTLE THE ABOVE CLAIM(S): $ 20,305.13
(required)

THIS FORM MUST BE SIGNED AND RETURNED TO THE CITY CLERK'S OFFICE WITH ALL REQUESTED INFORMATION IN ORDER TO BE PROCESSED.

I SWEAR AND/OR AFFIRM THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT.

CLAIMANT'S SIGNATURE

CLAIMANT'S SIGNATURE (if applicable)