CITY OF SPRINGFIELD, OHIO
Personal Injury Claim Statement Form

NAME	BIRTH DATE	HOME PHONE	CELL PHONE
STREET ADDRESS	CITY	STATE	ZIPCODE
EMAIL ADDRESS	EMPLOYER NAME		

DESCRIPTION OF INCIDENT

If you have photos of the damage that resulted, please attach them to this form.

INCIDENT DATE:	INCIDENT TIME:	INCIDENT LOCATION:
CITY DEPARTMENT INVOLVED, IF ANY:		NAME OF CITY EMPLOYEE INVOLVED, IF ANY:
POLICE REPORT MADE? YES: ☐ NO: ☐	POLICE REPORT #:	If no, why?
DESCRIPTION: (Please be as specific as possible in your description. Include as much detail as possible, such as who was with you, weather conditions, etc. If you require more space, please attach a separate sheet.)		

AFFIDAVIT OF INSURANCE

If uninsured, please complete the following:

I,_____, swear or affirm that I do not have Health insurance. Alternatively, I swear or affirm that I/my company is self-insured.

UNINSURED CLAIMANT SIGNATURE: _____ DATE: _____

If insured, please complete the following:

HEALTH INSURANCE COMPANY:	**HEALTH INSURANCE POLICY NUMBER:**

Ohio Revised Code, Section 2744.05 outlines limitations of damages awarded for claims against political subdivisions. If a claimant receives or is entitled to receive benefits from insurance policy or policies, that amount will be deducted from any award the political subdivision may consider paying. This includes Medicaid, Medicare and Health insurance policies.

You MUST file a claim with your insurance company prior to filing a claim with the City of Springfield. Documentation of filing of a claim with your insurance company must be attached to this Claim Packet. You must also submit a copy of your Health insurance Summary Plan Description with this Claim Packet.

FURTHERMORE, WITH RESPECT TO ANY DAMAGES ALLEGED IN THIS CLAIM PACKET, CLAIMANT MUST BE MADE AWARE THAT, BY STATUTE, THE CITY OF SPRINGFIELD, OHIO MAINTAINS SIGNIFICANT IMMUNITY FROM LIABILITY FOR DAMAGES OF THIS NATURE. OHIO REVISED CODE SECTION 2744.05 ADDRESSES THESE IMMUNITIES. IN SHORT, CLAIMANT MUST PROVE THAT THE CITY OF SPRINGFIELD WAS NEGLIGENT OR RECKLESS IN THEIR ACTIONS. IF THE CLAIMANT CANNOT PROVE, THROUGH THIS CLAIM PACKET, NOR THE CITY CAN FIND RECORDS INDICATING NEGLIGENCE OR RECKLESS BEHAVIOUR, THE CITY WILL MAINTAIN IMMUNITY AND WILL BE UNABLE TO PAY THE REQUESTED CLAIM.

I state that I am not entitled to receive any additional reimbursement for these damages from any other source other than the City of Springfield, and that the claim(s) arising from these damages are a direct result of this incident.

I,_____, attest that by signing below, I have read and understand the requirements for submission of a claim to the City of Springfield. I further understand that I MUST complete the Authorization for Release of Medical Records attached below and submit a signed, notarized version of the document to the City of Springfield Law Department.

CLAIMANTS SIGNATURE:_____DATE: _____

Send completed form with supporting documentation to law@springfieldohio.gov

☐ Completed Claim Form ☐ Photos of Damage ☐ Two Estimates ☐ Completed W9 Form

☐ Insurance Summary Plan Description ☐ Documentation a Claim has been filed with Insurance

☐ Signed and notarized Authorization for Release of Medical Records

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

I, Insert Name Here. , hereby authorize the release of any and all medical information and all records from physicians, psychiatrists, psychologists, counselors, social workers, therapists and any individuals providing health care, as well as any hospitals, clinics, doctor's offices, or health care providers including those listed below to the City of Springfield, Law Director Jill N. Allen, and any Assistant Law Director, and/or their agents.

- Outpatient treatment records for physical and psychological, psychiatric, emotional illness, or drug and/or alcohol abuse.
- Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- Treatment, recovery, rehabilitation, aftercare plans, and other similar plans.
- Social, family, educational, and vocational plans.
- Social work assessments and plans.
- Progress, nursing, case, or similar notes.
- Billing/Financial records.
- Information about how the patient's condition(s) affects or has affected his/herability to work and to complete tasks or activities of daily living.
- Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special education documents.
- HIV related information and drug and alcohol information.

For the date(s) of care beginning _____ to the present.

The information will be used only for purposes relating to a claim I have filed against the City of Springfield, Ohio. The authorization for release shall expire upon final adjudication of the aforementioned action. Any and all records shall be released to the City of Springfield, Law Director Jill N. Allen, and any Assistant Law Director, and/or their agents, located at 76 N. High St., Springfield Ohio, 45506.

I have the right to revoke this authorization at any time provided that said revocation is in writing and delivered to the City of Springfield, Law Director Jill N. Allen except to the extent that the City of Springfield has taken action in reliance of said authorization.

I realize the potential for information disclosed pursuant to this authorization to be subject to disclosure by the recipient and to no longer be protected by the Privacy Rule of the Health Insurance Portability and Accountability Act.

A copy of this authorization is valid as the original.

SIGNATURE: _____ DATE: _____

STATE OF OHIO)
COUNTY OF CLARK) SS:

SWORN TO BEFORE ME and subscribed in my presence the ____ day of _____, 20____.

_____
NOTARY PUBLIC, STATE OF OHIO