

TOWN OF FRIDAY HARBOR

Post Office Box 219 • Friday Harbor, Washington 98250
(360) 378 – 2810 • FAX: (360) 378 – 5339 • www.fridayharbor.org

STANDARD TORT CLAIM FORM PACKET

Please *carefully read all of the information in this packet* before completing and presenting your Standard Tort Claim.

DOCUMENTS CONTAINED IN THE STANDARD TORT CLAIM FORM PACKET:

- Instructions for completing the Tort Claim Form
- Tort Claim Form
- Medical Authorization Form

LEGAL REQUIREMENTS FOR PRESENTING TORT CLAIM FORMS:

In order to verify the claim and supporting information, the law requires that the Tort Claim Form be signed by:

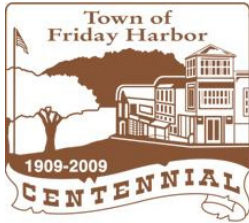
- Claimant; or
- Person holding a written power of attorney from the Claimant; or
- Attorney admitted to practice in Washington State on the Claimant's behalf; or
- Court-approved guardian or guardian ad litem on behalf of the Claimant.

PRESENT IN PERSON OR MAIL THE TORT CLAIM FORM AND SUPPORTING DOCUMENTS TO:

Town of Friday Harbor
Attn: Risk Manager
c/o C. King Fitch, Town Administrator
55 Second Street
Post Office Box 219
Friday Harbor, WA 98250

Business hours: Monday through Friday from 8:00 a.m. through 4:30 p.m. Closed on weekends and official holidays.

A claim is deemed presented when the Claim Form is delivered in person or is received by the Agent for the Town designated above via regular mail, registered mail, or certified mail with return receipt requested.



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INSTRUCTIONS FOR COMPLETING A STANDART TORT CLAIM FORM

Before filing a Tort Claim, please read these instructions in its entirety.

Type or print clearly in ink and sign the Tort Claim form.

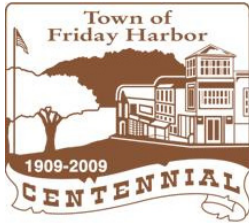
Provide all requested information and any available documents or evidence supporting your claim, such as medical records or bills for personal injuries, photographs, proof of ownership for property damages, receipts for property value, etc.

If the requested information cannot be supplied in the space provided, please use additional blank sheets so your claim can be easily read and understood.

If you are presenting a personal injury claim, please sign and attach the Medical Release form.

The following are examples on how to complete the Standard Tort Claim Form:

1. Smith, Karen Michelle February 11, 1965
2. 1234 College Way NW, Apt. 56, Seattle WA 98178
3. PO Box 910, Seattle WA 98178
4. Same (or residence at the time of incident)
5. (206) 123-4567 (425) 123-4569
6. jandoe@email.com
7. June 1, 2009 8:00 am
8. If the incident that caused the damages occurred over a period of time, please provide the beginning date and time listed in item 7 and the ending time and date.
9. Washington, Thurston, Tumwater, Campus of South Puget Sound Community College
10. I-5, Southbound, Milepost 109, near the Martin Way Exit
11. Washington State Department of Transportation
12. Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Seattle WA 98178 (360) 456-3456; Tow Truck Driver, Nisqually Towing
13. Doug Doe, Driver for Department of Transportation
14. List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items 11 and 12. Also include a description of their knowledge. For example, if your sister was with you, when the alleged incident occurred, please include her name, address, telephone number, and indicate she witnessed the incident.
15. List your injury or damage. Explain property loss or medical, physical or mental injuries, specifically answering the questions who, what, where, when and why.
16. If you reported this incident to law enforcement, safety, or security personnel, please provide a copy of the report or contact information to the person you spoke with.
17. Please provide information of all your medical providers with their names, addresses, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include your medical records and bills.
18. Attach receipts, pictures, witness statements or any other document to support your claims allegation.
19. Please provide the dollar amount for your damages, including your time loss, medical costs, property damage loss, etc. This amount should represent your opinion of total compensation.



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STANDARD TORT CLAIM FORM	For Town of Friday Harbor Use Only
General Liability Claim Form	
<p>Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against the Town of Friday Harbor. Information requested on this form is required by RCW 4.92.020 and may be subject to public disclosure. Claim forms cannot be submitted electronically (via e-mail or fax). A separate Claim form must be filed for each Claimant.</p>	
PLEASE TYPE OR PRINT IN INK	
Mail or deliver original claim to: C. King Fitch, Town Administrator Town of Friday Harbor PO Box 219 Friday Harbor, WA 98250	

CLAIMANT INFORMATION

1. Claimant's name (*Last, First, Middle*): _____ Date of birth (*mm/dd/yyyy*): _____

2. Current residential address: _____

3. Mailing address (if different): _____

4. Residential address for six months prior to the date of the incident (if different from current address): _____

5. Claimant's daytime telephone number(s): _____

(Home) _____ (Work) _____

6. Claimant's e-mail address: _____

INCIDENT INFORMATION

7. Date of the incident: _____ Time: _____

a.m. p.m. (*check one*)

8. If the incident occurred over a period of time, date of first and last occurrences:

From: _____, Time: a.m. p.m. (*check one*) To: _____, Time: a.m. p.m. (*check one*)

(mm/dd/yyyy) (mm/dd/yyyy)

9. Location of incident:

State; _____ County; _____ City; _____ Place of occurrence _____

10. If incident occurred on a street or highway:

Name of street; _____ Street Address; _____ At the intersection with or nearest intersecting street _____

INCIDENT INFORMATION

(continued)

12. Names, addresses and telephone numbers of all persons involved in or witness to this incident:

13. Names, addresses and telephone numbers of all Town of Friday Harbor employees having knowledge about this incident:

14. Names, addresses and telephone numbers of all individuals not already identified in #12 and #13 above that have knowledge regarding the liability issues involved in this incident, or knowledge of the Claimant's resulting damages. Please include a brief description as to the nature and extent of each person's knowledge. Attach additional sheets if necessary:

15. Describe the cause of the injury or damages. Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary:

16. Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom?

17. Names, addresses and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

18. Please attach and list documents including receipts, pictures, witness statements or any other documents to support the claim's allegations, including Police Incident Report if your claim involves a motor vehicle accident:

19. I claim damages from the Town of Friday Harbor in the sum of:

Dollars; (\$ _____).

SIGNATURE OF CLAIMANT

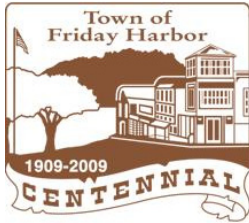
This claim form must be signed by the Claimant, a person holding a written power of attorney from claimant, an attorney for the Claimant, by an attorney admitted to practice in Washington State of behalf of the Claimant, or by a court-approved guardian or guardian ad litem on behalf of the claimant.

I declare under penalty of perjury und the laws of the State of Washington that the foregoing is true and correct.

Signature of Claimant

Date

Residential address, City and County



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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

If you are presenting a **claim for personal injury**, please sign and attach this release form for protected health information to your Tort Claim Form. A separate form must be submitted for each claimant.

CLAIMANT/PATIENT INFORMATION

1. Claimant's name (*Last, First, Middle*):

Date of birth (*mm/dd/yyyy*):

I hereby authorize disclosure of my protected health information to the Town of Friday Harbor, and/or its agent, for purposes of processing my claim for damages filed with the Town of Friday Harbor.

I understand that by signing this document, I authorize the release of the following information as it relates to my claim:

- Complete medical record for all services, including history and physical exam; progress notes; x-ray reports; inpatient admissions; operative notes; physical or other therapy; laboratory and other test reports; physician and physician assistant orders; nursing notes; and all other records and references designated by the provider as part of its medical record; and
- HIV Test Results and medical information related to HIV testing or treatment
- Psychiatric, mental and behavioral health records, including treatment notes, assessments, testing documents and results, and medical records related to mental health diagnosis and treatment; and
- Alcohol assessment, testing, referral or treatment records; and
- All other chemical dependency assessment of treatment records; and
- Pharmacy prescriptions and reports; and
- All letters and memos received or sent, including electronic mail, referencing my treatment, information related to alleged sexual assault or sexually transmitted disease, including test results; and
- Urgent care, outpatient or other clinic visit information; and
- Gynecological and/or obstetrical information; and
- All client records generated for or by governmental programs of which I am a client; and
- Financial records related to my care and treatment.

PLEASE READ AND INITIAL ALL STATEMENTS

I understand that my records are protected under HIPPA/PHI regulations (federal law) and the Washington State Health Care Information Act (RCW 70.02).

I understand that my health information may be subject to re-disclosure by the Town and not protected for purposes of evaluating and investigating the claim I have filed with the Town of Friday Harbor.

I understand that the specific information to be disclosed in my medical record may include information regarding alcohol, drug or other controlled substance use, counseling referrals and/or a history of testing or treatment of acquired immune deficiency syndrome.

I understand that I may revoke this Authorization at any time by notifying the Town in writing, and that the revocation will be effective as of the date Town receives it. Any records obtained pursuant to this Authorization prior to the revocation will be deemed authorized by me for release.

I understand that this Authorization will expire ninety (90) days from the date I sign it; and/or until my claim is resolved or closed by the Town. I may authorize an alternate time frame for this Authorization to be valid.

I understand that a copy of this Authorization carries the same authority as the original for the purposes of releasing my records to the Town.

SIGNATURE OF CLAIMANT

This claim form must be signed by the Claimant, a person holding a written power of attorney from claimant, an attorney for the Claimant, by an attorney admitted to practice in Washington State of behalf of the Claimant, or by a court-approved guardian or guardian ad litem on behalf of the claimant. Where the signer is not the subject of the records written proof must be attached.

Signature of Claimant/Patient

Date

Contact Information

