Standard Tort Claim Form Packet

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

- Type or print clearly in ink and sign the Standard 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; and,
  - Receipts for property value.
- If the requested information cannot be supplied in the space provided, please use additional blank sheets so that your Standard Tort Claim form can be easily read and understood.

Documents contained in Willapa Harbor Hospital's Standard Tort Claim Packet are:

1. Willapa Harbor Hospital's Standard Tort Claim Form.
2. A Vehicle Collision Form only for tort claims involving vehicle accidents/collisions.

Legal requirements for presenting Standard Tort Claims Forms:

- In order to verify the claim and additional supporting information, the law requires that Willapa Harbor Hospital's Standard Tort Claim Form be signed by:
  - Claimant; *or*
  - Person holding a written power of attorney from the Claimant; *or*
  - Attorney in fact for the Claimant; *or*
  - Attorney admitted to practice in Washington State on the Claimant's behalf; *or*
  - A court-approved guardian or guardian ad litem on behalf of the Claimant.
- Present in person or mail the Standard Tort Claim Form and supporting documents to:

Administrator – Willapa Harbor Hospital
PO Box 438 (800 Alder Street)
South Bend, WA 98586

Business Hours: Monday through Friday, 8:00 AM to 4:30 PM
Closed on weekends and holidays

Standard Tort Claim Form

General Liability Claim Form

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against **Willapa Harbor Hospital**. Some of the information on this form is required by RCW 4.92.100 and may be subject to public disclosure. Pursuant to law, Standard Tort Claim forms cannot be submitted electronically (via e-mail or fax).

For Official Use only
No.

PLEASE TYPE OR PRINT IN INK

Mail or deliver original claim to:

Administrator - Willapa Harbor Hospital
PO Box 438 (800 Alder Street)
South Bend, WA 98586

Business Hours are .
Monday through Friday: 8:00 AM - 4:30 PM

CLAIMANT INFORMATION:

1. Claimants name: ____
   Last name First Middle Date of Birth (mm/dd/yyyy)

2 Current residential address: ____

3. Mailing address (if different) ____

4. Residential address at the time of the incident (if different from current address):
   ____

5. Claimant's daytime telephone number: Home:_____-_____-_______ Business: ____-____-_______

6. Claimant's e-mail address: ____

INCIDENT INFORMATION:

7. Date of the incident: _____/_____/________ Time: __________ AM PM
   (mm/dd/yyyy) (circle one)

8. If the incident occurred over a period of time, date of first and last occurrences:
   from ____/____/______ Time: _____ AM PM to____/____/______ Time _____ AM PM
   (circle one) (circle one)

9. Location of incident: ____
   State and County City (if applicable) Place where occurred

10. If the incident occurred on a street or highway:
    ____
    Name of street or highway Milepost Number At the intersection with or nearest intersecting street

INSTRUCTIONS FOR COMPLETING A TORT CLAIM FORM

General Liability Claim Form #SF 210

- ✓ Before filing a Tort Claim, please read these instructions, the Tort Claim form and other appropriate forms in their entirety.
- ✓ Type or print **clearly** in ink and sign the Tort Claim form. **Do not staple or tape documents.** Do not put in claim form in binders or add divider tabs as all documents must be scanned.
- ✓ 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.

- ✓ The following are *examples* on how to complete the Tort Claim Form #SF 210:

1) Smith, Karen Michelle – 02/20/1965
2) #809234 (for use by Department of Corrections inmates only)
3) 1234 College Way NW, Apt. 56, Seattle WA 98178
4) PO Box 910, Seattle WA 98178
5) Same (or residence at the time of incident)
6) (206) 123-4567 – (206) 987-6543
7) KMSmith@hotmail.com
8) 8/9/2010 8:00 a.m.,
9) If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item 8.
10) Washington, Thurston, Tumwater, Campus of South Puget Sound Community College, Building number 22.
11) I-5, Southbound, Milepost 109, near the Martin Way Exit
12) Washington State Department of Transportation, Highway
13) Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Seattle WA 98178 (360) 456-3456; Tow Truck Driver, Nisqually Towing
14) Unknown
15) List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items 13 and 14. 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.
16) Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.
17) 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.
18) Please provide all of your medical providers with their names, address, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include your medical records and bills.
19) Please attach any additional documents that support your claim.
20) 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.

- ✓ If you are filing a personal injury claim, please sign and attach the Medical Release.
- ✓ If your claim involves a motor vehicle accident, please complete, sign, and attach the vehicle accident form.

VEHICLE COLLISION FORM

PLEASE TYPE OR PRINT IN INK

Please attach this form to your standard tort claim form, if the claim involves a vehicle collision.

CLAIMANT AND INCIDENT INFORMATION

CLAIMANT'S NAME (A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)	DATE OF ACCIDENT(mm/dd/yyyy)	TIME AM ☐ PM ☐

CURRENT STREET (RESIDENCE) ADDRESS	CITY	STATE	ZIP	PHONE HOME WORK

(RESIDENCE) STREET ADDRESS FOR SIX MONTHS PRIOR TO THE ACCIDENT	CITY	STATE	ZIP	EMAIL

State/County/City (if applicable) where occurred	STREET OR HWY	MILEPOST NO.	INTERSECTION OR NEAREST STREET/ROAD

YOUR VEHICLE INFORMATION (VEHICLE #1)

YEAR	MAKE	MODEL	LICENSE PLATE NO.	WHERE CAN CAR BE SEEN?	WHEN?

NAME OF VEHICLE OWNER	ADDRESS	CITY	HOME AND WORK PHONE

NAME OF DRIVER	ADDRESS	CITY	HOME AND WORK PHONE

DRIVER'S LICENSE NUMBER	STATE OF ISSUANCE	DATE OF EXPIRATION

DESCRIBE DAMAGE	ESTIMATE $	YOUR INSURANCE COMPANY AND POLICY NO.

OTHER VEHICLE INFORMATION (VEHICLE #2)

YEAR	MAKE	MODEL	LICENSE PLATE NO.	STATE AGENCY, IF KNOWN

NAME OF OWNER	ADDRESS	CITY	PHONE

NAME OF DRIVER	ADDRESS	CITY	PHONE

DESCRIBE DAMAGE	ESTIMATE $

OTHER NON-VEHICLE DAMAGE

WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.

NAME OF OWNER	ADDRESS	CITY	PHONE

DESCRIBE DAMAGE	ESTIMATE $

INJURED PARTIES

NAME	ADDRESS	PHONE	INJURY	AGE	VEH 1	VEH 2	VEH 3	PED	OTH
		HOME WORK							
		HOME WORK							
		HOME WORK							
		HOME WORK							
		HOME WORK							

WITNESSES

NAME (ATTACH ADDITIONAL SHEETS IF NECESSARY)	ADDRESS	CITY	PHONE
			HOME WORK
			HOME WORK
			HOME WORK

SF 138 (July 2009)

COMPLETE ALL DETAILS

Describe conduct and circumstances causing injury or damages and explain the extent of medical, physical or mental injuries. Please identify name, address, and telephone number of treating physicians and other medical providers. Please attach property damage estimates and/or all medical bills in support of your claim. If necessary, attach additional pages containing information in this format.

____

____

____

____

____

____

☐ Straight Road
☐ Curve – R or L
☐ Level

☐ Hillcrest
☐ Uphill
☐ Downhill

☐ One Lane
☐ One and One-Half Lane
☐ Two Lane or Four Lane

Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.

Sidewalk

Street

Center

Sidewalk

IMPORTANT

If street or view was obstructed in any way, indicate where and how; also indicate any street car or tracks and traffic signals or signs.

Indicate points of compass N. E. S. W.

Mark Damaged Areas

RIGHT

VEH. 1

RIGHT

VEH. 2

LIGHT CONDITIONS (CHECK ONE)	TRAFFIC CONTROL	TYPE OF ROAD (CHECK ONE OR MORE)	VEHICLE CONDITION (CHECK ONE OR MORE)	ROAD SURFACE (CHECK ONE)	WEATHER (CHECK ONE)
	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	
1 ☐ DAYLIGHT	☐ 1 ☐ SIGNALS	☐ 1 ☐ ONE WAY	☐ 1 ☐ DEFECTIVE BRAKES	☐ 1 ☐ DRY	1 ☐ CLEAR, CLOUDY & OVERCAST
2 ☐ DAWN	☐ 2 ☐ STOP SIGN	☐ 2 ☐ TWO WAY	☐ 2 ☐ DEFECTIVE HEADLIGHTS	☐ 2 ☐ WET	2 ☐ RAINING
3 ☐ DUSK	☐ 3 ☐ FLASHING RED	☐ 3 ☐ REVERSIBLE ROAD	☐ 3 ☐ DEFECTIVE REAR LIGHTS	☐ 3 ☐ SNOW	3 ☐ SNOWING
4 ☐ DARK STREET LIGHTS ON	☐ 4 ☐ FLASHING AMBER	☐ 4 ☐ INTER-CHANGE LOOP RAMP	☐ 4 ☐ TIRES WORN	☐ 4 ☐ ICE	4 ☐ FOG
5 ☐ DARK STREET LIGHTS OFF	☐ 5 ☐ RR SIGNAL	☐ 5 ☐ ALLEY	☐ 5 ☐ PUNCTURED OR BLOWN TIRES	☐ 5 ☐ OTHER (SPECIFY)	5 ☐ OTHER (SPECIFY)
6 ☐ DARK NO STREET LIGHT	☐ 6 ☐ OFFICER/ FLAGMAN	☐ 6 ☐ TWO WAY-LEFT TURN LANES	☐ 6 ☐ OTHER (SPECIFY)		
7 ☐ OTHER (SPECIFY)	☐ 7 ☐ YIELD SIGN	☐ 1 ☐ SEPARATED		NAME OF INVESTIGATING POLICE AGENCY: ____________	
	☐ 8 ☐ NO TRAFFIC CONTROL	☐ 2 ☐ DIVIDED		INVESTIGATING AGENCY REPORT NO. ____________	
	☐ 9 ☐ OTHER	☐ 3 ☐ UNDIVIDED			

A separate claim form should be submitted for each claimant.

This information is being provided to aid in resolving the claim.

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

______________________________ ______________________________

Signature of Claimant *Date and Place (residential address, city and county)*

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

Name	Number	Name	Number
______________________	_____-_____-_______	______________________	_____-_____-_______
______________________	_____-_____-_______	______________________	_____-_____-_______
______________________	_____-_____-_______	______________________	_____-_____-_______

12. Names, addresses and telephone numbers of Hospital employees having knowledge of this incident.

13. Names address and telephone numbers of all individuals not already identified in #11 and #12 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.

14. 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.

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

16. Names, address and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

17. Please attach documents which support the claim's allegations.

18. I claim damages from PHD _______________y in the sum of $_________________.

This Standard Tort Claim Form must be signed by the Claimant, a person holding a written power of attorney from the Claimant, by the attorney-in-fact for the Claimant, by an attorney admitted to practice in the State of Washington on the Claimant's behalf, or by a court-appointed guardian or guardian ad litem on behalf of the Claimant.

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

______________________________ ______________________________

Signature of Claimant Date and place (residential address, city and county)