Standard Tort Claim Form Packet

Please *carefully read all of the information in this packet* before completing and submitting your Standard Tort Claim. Please note that no documents will be returned.

Presenting a Standard Tort Claim Form

Engrossed Substitute House Bill 1SS3, effective July 26, 2009, requies citizens to present the Standard Tort Claim form that is maintained by the Risk Management Division of the Washington State Office of Financial Management ("OFM_RMD:) with the Agent appointed to receive any claim for damages made against the Port of Pasco. The law also requires OFM-RMD to post on its website the Standard Tort Claim form with instructions. In compliance with these requirements and for the convenience of citizens, the Port of Pasco developed a Standard Tort Claim Form Packet

Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Tort Claim Form
2. Standard Tort Claim Form
3. Medical Authorization
4. Vehicle Collision Form only for tort claims involving vehicle accidents/collisions

Legal Requirements for Presenting Standard Tort Claim Forms

In order to verify the claim and additional supporting information, the law requires that the 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

Submit the Standard Tort Claim Form and Supporting Documents by mail or in person to:

Lori French
Executive Assistant & Human Resources
Port of Pasco
1110 Osprey Pointe Blvd., Suite 201
Pasco, WA 99301

Business Hours: Monday-Friday, 7:00 a.m. to noon and 1:00 p.m. to 4:00 p.m. Closed on weekends and official state holidays.

INSTRUCTIONS FOR COMPLETING A TORT CLAIM FORM

General Liability Claim Form

- ✓ 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:

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.

STANDARD TORT CLAIM FORM

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against the Port of Pasco (Agency). Some of the information required on this form is required by RCW 4.96.020 and may be subject to public disclosure. Pursuant to the new law, Standard Tort Claim forms cannot be submitted electronically (via e-mail or fax).

PLEASE TYPE OR PRINT CLEARLY IN INK

Mail or deliver original claim to Lori French
Executive Staff Assistant & Human Resources
Port of Pasco
1110 Osprey Pointe Blvd., Suite 201
Pasco, WA 93301

Business Hours: Monday-Friday, 7:00 a.m. to noon and 1:00 p.m. to 4:00 p.m. Closed on weekends and official state holidays.

1. Claimant's 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 or Cell

6. Claimant's e-mail address: _____

INCIDENT INFORMATION

7. Date of the incident: _____ Time:_____ ☐ a.m. ☐ p.m. (check one)
   (mm/dd/yyyy)

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

   from _____ Time: _____ ☐ a.m. ☐ p.m.
   (mm/dd/yyyy) (mm/dd/yyyy)

   to _____ Time:_____ ☐ a.m. ☐ p.m.
   (mm/dd/yyyy) (mm/dd/yyyy)

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

11. Agency alleged responsible for damage/injury:

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

13. Names, addresses and telephone numbers of all Agency 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 documents which support the allegations of the claim.

19. I claim damages from the Port of Pasco in the sum of $_____.

This 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 Washington State on the Claimant's behalf, or by a court-approved 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)***
Or	
Signature of Representative	***Date and place (residential address, city and county)***
Print Name of Representative	***Bar Number (if applicable)***

Authorization for Release of Protected Health Information (PHI)
to
Department of Enterprise Services, Office of Risk Management

Name: _____
(Last, First, Middle Initial or Middle Name)

Date of Birth: Month _____ Day ____ Year _____

I hereby authorize disclosure of my protected health information to the Port of Pasco, for purposes of processing my claim for damages filed with the Port of Pasco.

I understand that by signing this document, I authorize the release of the following information:

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.

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

Alcohol assessment, testing, referral or treatment records

All other chemical dependency assessment of treatment records

Pharmacy prescriptions and reports

All letters and memos received or sent, including electronic mail, referencing my treatment, compliance with treatment and any other subject related to my medical treatment

Information related to alleged sexual assault or sexually transmitted disease, including test results

Urgent care, outpatient or other clinic visit information

Gynecological and/or obstetrical information

All client records generated for or by governmental programs of which I am a client. Identify the program(s) and agency: _____.

Financial records related to my care and treatment

I understand the following: **(PLEASE READ AND INITIAL ALL STATEMENTS)**

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

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

_____ Initials 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.

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

_____ Initials I understand that this Authorization for Release will expire 90 days from the date I sign it. I can also authorize a different time frame for this release to be valid. This permission is valid until my claim is resolved or closed by Port of Pasco.

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to the Port of Pasco.

Signature of Authorizing Individual:

_____

Date of Signature: _____

Telephone number: _____

Witness (where patient is over 13 and signing the release):

_____

Where the signer is not the subject of the records:

I am authorized to sign this because I am the (attach proof of authority):

- ☐ Parent of minor
- ☐ Legal Guardian
- ☐ Personal Representative
- ☐ Other

_____

To the Provider or Records Custodian:

Please send legible copies of all records to:

Lori French
Executive Staff Assistant & Human Resources
Port of Pasco
1110 Osprey Pointe Blvd., Suite 201
Pasco, WA 99301

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

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.

_____

_____

_____

_____

_____

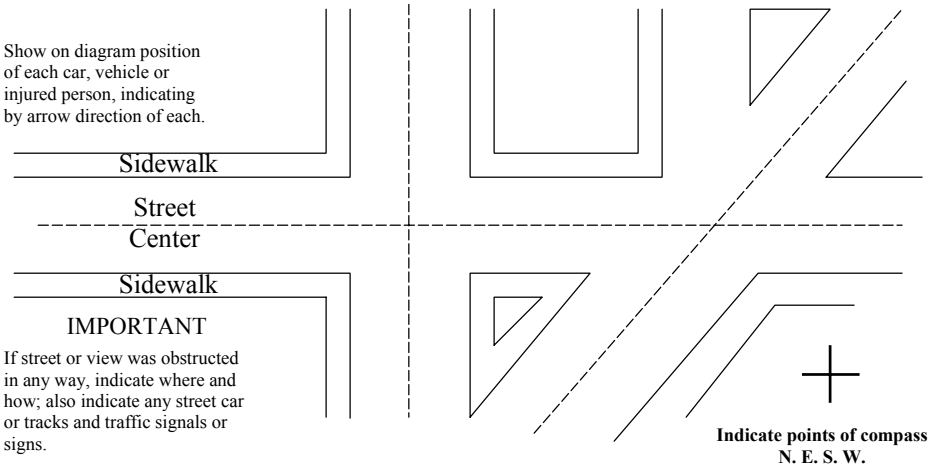
_____

☐ 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.

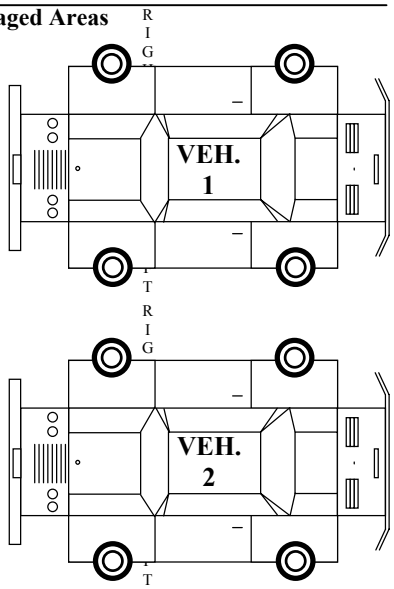


IMPORTANT

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



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)
1 ☐ DAYLIGHT	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	1 ☐ CLEAR, CLOUDY & OVERCAST
2 ☐ DAWN	1 ☐ ☐ SIGNALS	1 ☐ ☐ ONE WAY	1 ☐ ☐ DEFECTIVE BRAKES	1 ☐ ☐ DRY	2 ☐ RAINING
3 ☐ DUSK	2 ☐ ☐ STOP SIGN	2 ☐ ☐ TWO WAY	2 ☐ ☐ DEFECTIVE HEADLIGHTS	2 ☐ ☐ WET	3 ☐ SNOWING
4 ☐ DARK STREET LIGHTS ON	3 ☐ ☐ FLASHING RED	3 ☐ ☐ REVERSIBLE ROAD	3 ☐ ☐ DEFECTIVE REAR LIGHTS	3 ☐ ☐ SNOW	4 ☐ FOG
5 ☐ DARK STREET LIGHTS OFF	4 ☐ ☐ FLASHING AMBER	4 ☐ ☐ INTER-CHANGE LOOP RAMP	4 ☐ ☐ TIRES WORN	4 ☐ ☐ ICE	5 ☐ OTHER (SPECIFY)
6 ☐ DARK NO STREET LIGHT	5 ☐ ☐ RR SIGNAL	5 ☐ ☐ ALLEY	5 ☐ ☐ PUNCTURED OR BLOWN TIRES	5 ☐ ☐ OTHER (SPECIFY)	
7 ☐ OTHER (SPECIFY)	6 ☐ ☐ OFFICER/ FLAGMAN	6 ☐ ☐ TWO WAY-LEFT TURN LANES	6 ☐ ☐ 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)***