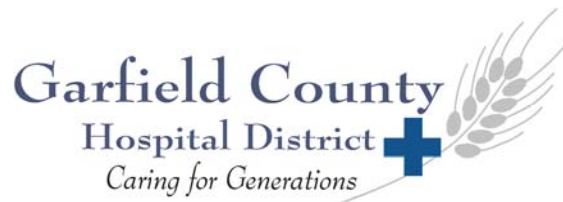


# Instructions for Filing a Tort Claim



This packet includes information needed to file a tort claim against Garfield County Public Hospital District No. 1, Garfield County Washington.

RCW 4.96.020 requires a claim to be filed with the public entity and the claimant must then wait 60 days before filing suit. If a claimant files suit prematurely, the public entity can get the suit dismissed by filing a motion with the court. The public entity must have available to the public a standard claim form with instructions regarding how to file it and the name of the agent appointed to receive the claim. Henceforth the following:

1. Review the attached documents in their entirety
2. The packet includes the following information
  - a. This notice
  - b. Resolution 01-03 APPROVING AND ADOPTING PROCEDURES FOR PRESENTING CLAIMS FOR DAMAGES ARISING OUT OF THE TORTIOUS CONDUCT OF THE DISTRICT OR ITS OFFICERS, EMPLOYEES OR VOLUNTEERS.
  - c. Standard Tort Claim Form Packet
3. Complete the Standard Tort Claim Form (SF 210)
4. Submit the completed claim form to the Agent of the District at the following address:

CEO  
66 North Sixth Street  
Pomeroy, WA 99347

Phone: 509-843-1591

Fax: 509-843-1234

**Public Hospital District No. 1,  
Garfield County, Washington**

**Resolution No. 01-03**

A RESOLUTION OF THE BOARD OF COMMISSIONERS OF PUBLIC HOSPITAL DISTRICT NO. 1, GARFIELD COUNTY, WASHINGTON (THE "DISTRICT"), APPROVING AND ADOPTING PROCEDURES FOR PRESENTING CLAIMS FOR DAMAGES ARISING OUT OF THE TORTIOUS CONDUCT OF THE DISTRICT OR ITS OFFICERS, EMPLOYEES OR VOLUNTEERS.

WHEREAS, Chapter 4.96 RCW sets forth the procedures for presenting claims for damages arising out of the tortious conduct of local governmental entities, including public hospital districts, or the tortious conduct of their past or present officers employees or volunteers while performing or in good faith purporting to perform their official duties; and

WHEREAS, RCW 4.96.020, as amended by Chapter 119, Laws of 2001, requires local governmental entities to appoint an agent to receive any claim for damages made under Chapter 4.96 RCW;

NOW THEREFORE, THE BOARD OF COMMISSIONERS OF PUBLIC HOSPITAL DISTRICT NO. 1, GARFIELD COUNTY WASHINGTON, HEREBY RESOLVES AS FOLLOWS:

Section 1. In accordance with RCW 4.96.020, as amended by Chapter 119, Laws of 2001, the Board of Commissioners hereby appoints the Administrator of the District to act as an agent (the "Agent") to receive any claim for damages made under Chapter 4.96 RCW. The Chief Financial Officer is hereby appointed to act as a deputy agent ("Deputy Agent") to serve in the place of the Agent if Agent is unavailable to perform his or her duties.

Section 2. In accordance with RCW 4.96.020, the Board of Commissioners hereby adopts the following procedures for presenting claims for damages made under Chapter 4.96 RCW:

(a) Recording Information with Auditor. The identity of the Agent and Deputy Agent and the address where they may be reached during the normal business hours of the District shall be recorded by the District with the auditor of the county (the "Auditor") in which the District is located.

(b) Procedure for Presenting Claims. All claims for damages made under Chapter 4.96 RCW shall be presented personally to the Agent or Deputy Agent at the address and within the business hours recorded with the Auditor and shall be presented within the applicable period of limitations for which an action must be commenced.

(c) Content of Claim. All claims for damages arising out of tortious conduct shall locate and describe the conduct and circumstances which brought about the injury or damage, describe the injury or damage, state the time and place the injury or damage occurred, state the names of all persons involved, if known, and shall contain the amount of damage claimed, together with a statement of actual residence of the claimant at the time of presenting and filing the claim for a period of six months immediately prior to the time the claim arose.

(d) Alternative Representative of Claimant. If claimant is incapacitated from verifying, presenting and filing the claim in the time prescribed, or if the claimant is a minor, or if the claimant is a non-resident of the state absent therefrom during the time within which the claim was required to be filed, the claim may be verified, presented and filed on behalf of the claimant by any relative, attorney or agent representing the claimant.

(e) Notice Period. No action shall be commenced against the District for damages arising out of tortious conduct until sixty days have elapsed after the claim has first been presented to and filed in accordance with Chapter 4.96 RCW and this resolution.

ADOPTED AND APPROVED by the Commission of Public Hospital District No. 1, Garfield County, Washington, at a regular open public meeting thereof held this 25<sup>th</sup> day of July 2001, the following Commissioners being present and voting in favor of this resolution.

\_\_\_\_\_  
President and Commissioner

\_\_\_\_\_  
Commissioner

\_\_\_\_\_  
Commissioner

\_\_\_\_\_  
Commissioner

\_\_\_\_\_  
Commissioner

# Standard Tort Claim Form Packet

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

## A New Law that Impacts Presenting a Standard Tort Claim Form

Engrossed Substitute House Bill 1553, effective July 26, 2009, requires citizens to present the Standard Tort Claim form with the Office of Financial Management (OFM), Risk Management Division (RMD). 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, OFM 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 (SF 210)
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

## Present in Person or Mail the Standard Tort Claim Form and Supporting Documents to:

Risk Management Division  
Office of Financial Management  
General Administration Building, Room 300  
210 11th Avenue SW  
P.O. Box 43113  
Olympia, WA 98504-3113

Business Hours: Monday-Friday, 8:00 a.m. to 5:00 p.m.  
Closed on weekends and official state holidays.

## INSTRUCTIONS FOR COMPLETING A STANDARD TORT CLAIM FORM #SF 210

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- Before presenting a Standard Tort Claim form, please read these instructions, the Standard Tort Claim form, and other appropriate forms in their entirety.
- 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, receipts for property value, etc.
- If the requested information cannot be supplied in the space provided, please use additional blank sheets so your Standard Tort Claim form can be easily read and understood.
- The following are examples on how to complete the Standard Tort Claim Form (#SF 210):
  1. Smith, Karen Michelle
  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
  6. 8:00 a.m., August 9, 2008
  7. If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item 7
  8. Washington, Thurston, Tumwater, Campus of South Puget Sound Community College, Building number 22
  9. I-5, Southbound, Milepost 109, near the Martin Way Exit
  10. Washington State Department of Transportation, Highway
  11. Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Seattle WA 98178 (360) 456-3456; Tow Truck Driver, Nisqually Towing
  12. Unknown
  13. 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.
  14. 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.
  15. Please describe the incident that resulted in the injury or damages, 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 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 presenting a personal injury claim, please sign and attach the Medical Release form.
- If your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision Form.

# STANDARD TORT CLAIM FORM

General Liability Claim Form #SF 210

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against the State of Washington. Some of the information requested on this form is required by RCW 4.92.100 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).

For Official Use Only

## PLEASE TYPE OR PRINT IN INK

**Mail or deliver original claim to** Office of Financial Management  
Risk Management Division  
General Administration Building, Room 300  
210 11th Avenue SW  
Post Office Box 4HFFH  
Olympia, Washington 98504-HFFH

No.

Business Hours: Mon. - Fri. 8:00 a.m. - 5:00 p.m.  
Closed on weekends and official state holidays.

## CLAIMANT INFORMATION

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
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. (check one) to \_\_\_\_\_, Time: \_\_\_\_\_ a.m. p.m. (check one)  
(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. State agency or department alleged responsible for damage/injury: \_\_\_\_\_

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



**Authorization for Release of Protected Health Information (PHI)  
to  
The Office of Financial Management (OFM) Risk Management Division**

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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 Office of Financial Management, Risk Management Division, for purposes of processing my claim for damages filed with the State of Washington.

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 or treatment records

Pharmacy prescriptions and reports

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

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

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

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

\_\_\_\_\_ I understand that my health information may be subject to re-disclosure by OFM and not  
Initials protected for purposes of evaluating and investigating the claim I have filed with the State of  
Washington.

\_\_\_\_\_ I understand that the specific information to be disclosed in my medical record may include  
Initials 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 OFM in writing, and that  
Initials the revocation will be effective as of the date OFM 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.

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

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

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

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### To the Provider or Records Custodian

Please send legible copies of all records to:

The Office of Financial Management  
Risk Management Division  
General Administration Building, Room 300  
10 11th Avenue SW  
P.O. Box 4HFFH  
Olympia, WA 98504-HFFH

# 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 <b>(A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)</b>				DATE OF ACCIDENT(mm/dd/yyyy)		TIME AM <input type="checkbox"/> PM <input type="checkbox"/>			
	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.

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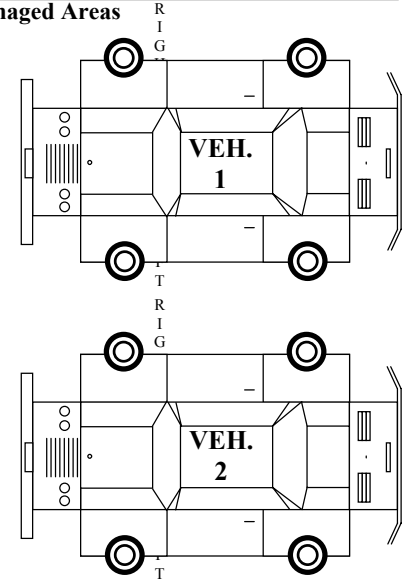
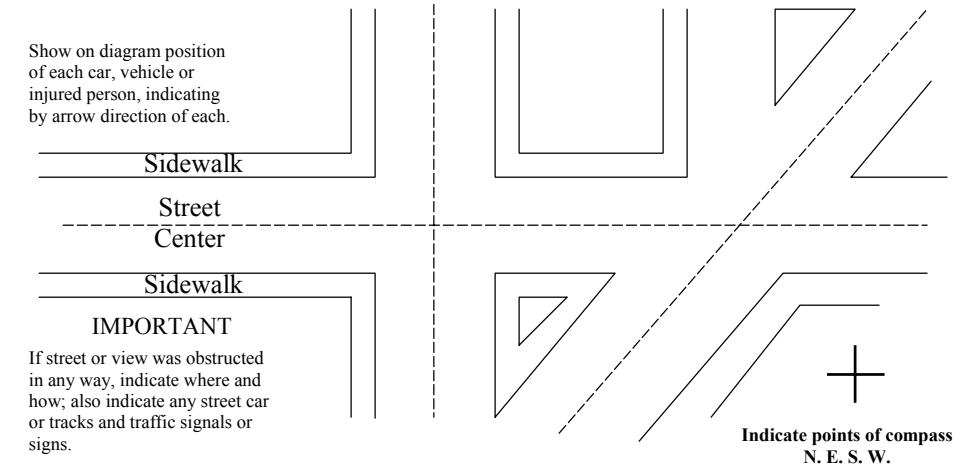


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- |   |                                    |  |
|---|------------------------------------|--|
| <input type="checkbox"/> Straight Road  | <input type="checkbox"/> Hillcrest | <input type="checkbox"/> One Lane              |
| <input type="checkbox"/> Curve – R or L | <input type="checkbox"/> Uphill    | <input type="checkbox"/> One and One-Half Lane |
| <input type="checkbox"/> Level          | <input type="checkbox"/> Downhill  | <input type="checkbox"/> Two Lane or Four Lane |



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