

# Standard Tort Claim Form Packet

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 to the agent or other person designated to accept delivery at the agent's office. The law also requires the District to provide a Standard Tort Claim form with instructions. In compliance with these requirements and for the convenience of citizens, Public Hospital District No. 1 of Mason County 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. 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:

Eric Moll  
Superintendent of the District  
901 Mt. View Drive  
Bldg 1  
Shelton, WA 98584

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

- 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:
  1. Smith, Karen Michelle
  2. 1234 College Way NW, Apt. 56, Seattle WA 98178
  3. P0 Box 910, Seattle WA 98178
  4. Same (or residence at the time of incident)
  5. 206-123-4567
  6. [Smith@hotmail.com](mailto:Smith@hotmail.com)
  7. 8:00 a.m., August 9, 2008
  8. 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
  9. Washington, Thurston, Tumwater, Campus of South Puget Sound Community College, Building number 22
  10. 1-5, Southbound, Milepost 109, near the Martin Way Exit
  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 describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.
  15. 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.
  16. 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.
  17. Attach any documents which support your claim.
  18. 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 your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision Form.

For Official Use Only
No.

***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 <input type="checkbox"/> PM <input type="checkbox"/>			
	CURRENT STREET (RESIDENCE) ADDRESS				CITY		STATE		ZIP			
	(RESIDENCE) STREET ADDRESS FOR SIX MONTHS PRIOR TO THE ACCIDENT				CITY		STATE		ZIP			
	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 \$				
	WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.											
OTHER NON-VEHICLE DAMAGE	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.

# Standard Tort Claim Form

## General Liability Claim Form

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against \_\_\_\_\_ . 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).

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**PLEASE TYPE OR PRINT IN INK**

Mail or deliver original claim to:

*Business Hours are .*

**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

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

Name	-	-	Name	-	-
<small>Number</small>			<small>Number</small>		<small>Number</small>
	-	-		-	-
<small>Number</small>			<small>Number</small>		<small>Number</small>
	-	-		-	-
<small>Number</small>			<small>Number</small>		<small>Number</small>

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

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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.

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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.

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

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

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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.*

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*Signature of Claimant*

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Date and place (residential address, city and county)