

# Clallam County

## 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 to the agent for a local government entity. In compliance with these requirements and for the convenience of citizens, Clallam County has 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

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

Clallam County Auditor  
Clallam County Courthouse  
223 East Fourth Street, Suite 1  
Port Angeles, WA 98362-3015

Business Hours: Monday-Friday, 8:30 a.m. to 4:30 p.m.  
Closed on weekends and County holidays.

## INSTRUCTIONS FOR COMPLETING CLALLAM COUNTY STANDARD TORT CLAIM FORM

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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 Clallam County Standard Tort Claim Form :
  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.

# CLALLAM COUNTY STANDARD TORT CLAIM FORM

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against Clallam County. Some of the information requested 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 IN INK

## Mail or deliver

**original claim to:** Clallam County Auditor  
Clallam County Courthouse  
223 East Fourth Street, Suite 1  
Port Angeles, WA 98362-3015

Business Hours: Mon. – Fri. 8:30 a.m. – 4:30 p.m.  
Closes on weekends and County holidays.

For Official Use Only

No.

## 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:  
\_\_\_\_\_

<i>Name of street or highway</i>	<i>Milepost number</i>	<i>At the intersection with or nearest intersecting street</i>
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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:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**13.** Names, addresses and telephone numbers of all state employees having knowledge about this incident:

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**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.

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**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.

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

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

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**18.** Please attach documents which support the claim's allegations.

**19.** I claim damages from Clallam County 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.

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***Signature of Claimant***

July 26, 2009

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***Date and place (residential address, city and county)***

**Authorization for Release of Protected Health Information (PHI)  
to  
The Clallam County Human Resources Department (CCHRD)**

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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 CCHRD, for purposes of processing my claim for damages filed with Clallam County.

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)**

\_\_\_\_\_  
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 CCHRD and not protected for purposes of evaluating and investigating the claim I have filed with Clallam County Washington.

\_\_\_\_\_  
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 CCHRD in writing, and that the revocation will be effective as of the date CCHRD 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 the CCHRD.

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

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:

Clallam County Human Resources Department  
Clallam County Courthouse  
223 East Fourth Street, Suite 16  
Port Angeles, WA 98362-3015

# 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.

<b>CLAIMANT AND INCIDENT INFORMATION</b>	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	PHONE HOME WORK			
	(RESIDENCE) STREET ADDRESS FOR SIX MONTHS PRIOR TO ACCIDENT			CITY	STATE	ZIP	EMAIL			
	STATE/COUNTY/CITY (if applicable) where occurred		STREET OR HWY		MILEPOST NO.		INTERSECTION OR NEAREST STREET/ROAD			
<b>YOUR VEHICLE INFORMATION (VEHICLE #1)</b>	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.				
<b>OTHER VEHICLE INFORMATION (VEHICLE #2)</b>	YEAR	MAKE	MODEL	LICENSE PLATE NO.	STATE/LOCAL AGENCY, IF KNOWN					
	NAME OF OWNER			ADDRESS	CITY	PHONE				
	NAME OF DRIVER			ADDRESS	CITY	PHONE				
	DESCRIBE DAMAGE						ESTIMATE \$			
<b>OTHER NON-VEHICLE DAMAGE</b>	WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.									
	NAME OF OWNER			ADDRESS	CITY	PHONE				
	DESCRIBE DAMAGE						ESTIMATE \$			
<b>INJURED PARTIES</b>	NAME	ADDRESS	PHONE	INJURY	AGE	VEH1	VEH2	VEH3	PED	OTH
			HOME WORK							
			HOME WORK							
			HOME WORK							
			HOME WORK							
			HOME WORK							
<b>WITNESSES</b>	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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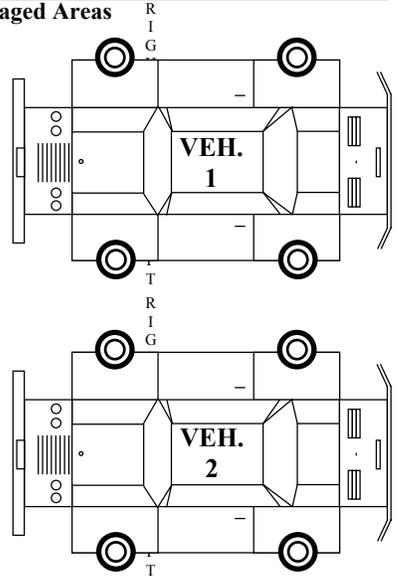


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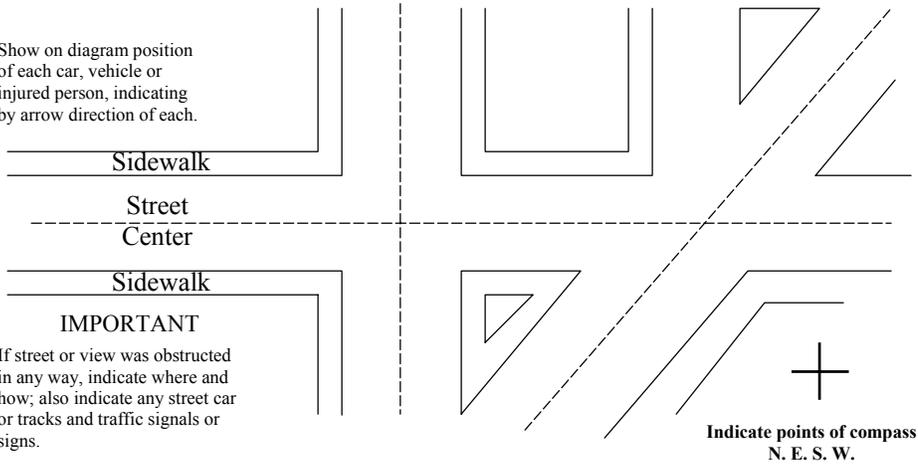


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- |   |                                    |  |
|---|------------------------------------|--|
| <input type="checkbox"/> Straight Road  | <input type="checkbox"/> Hillcrest | <input type="checkbox"/> One Lane              |
| <input type="checkbox"/> 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 |



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



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)*