

PUBLIC HOSPITAL DISTRICT NO. 1 OF SNOHOMISH COUNTY

STANDARD TORT CLAIM FORM PACKET

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

PURPOSE OF THE FORMS

The following documents are to be used to file a tort claim against Public Hospital District No. 1 of Snohomish County (the "District"), its officers, employees or volunteers for damages as defined under RCW 4.96.020.

FORMS PROVIDED

In this packet are the following forms:

- Instructions for completing the Standard Tort Claim Form
- Standard Tort Claim Form
- Medical Authorization
- Vehicle Collision Form (only for tort claims involving vehicle accidents / collisions)

LEGAL REQUIREMENTS

The law requires the completed forms be presented in person or mailed to the Agent of Record for the District (email or fax forms will not be accepted). The Agent of Record is available Monday through Friday 8:30 a.m. to 4:30 p.m., except official state holidays. The packet may be mailed to:

Norma Walker
Administration Executive Assistant
Public Hospital District No. 1 of Snohomish County
14701 179th Avenue SE
PO Box 646
Monroe, WA 98272

The law also 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

PUBLIC HOSPITAL DISTRICT NO. 1 OF SNOHOMISH COUNTY
INSTRUCTIONS FOR COMPLETING THE
STANDARD TORT CLAIM FORM

1. Please read these instructions, review the Standard Tort Claim form and other appropriate forms in their entirety.
2. Type or print clearly in ink and sign the Standard Tort Claim form.
3. Provide all requested information and any other valuable 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.
4. 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.
5. If you are presenting a personal injury claim, please sign and attach the Medical Release form.
6. If your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision form.
7. The law also 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

PUBLIC HOSPITAL DISTRICT NO. 1 OF SNOHOMISH COUNTY

STANDARD TORT CLAIM FORM

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against the District. 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 (i.e., email or fax).

Please type or print in ink

Mail or deliver original claim and all appropriate forms and documentation to:

Norma Walker
Administration Executive Assistant
14701 179th Avenue SE
PO Box 646
Monroe, WA 98272

Business hours are Monday through Friday 8:30 a.m. to 4:30 p.m. except official state holidays.

CLAIMANT INFORMATION

1. Claimant's name _____
Last *First* *Middle*
2. Claimant's date of birth (mm/dd/yyyy) _____
3. Current residential address _____
4. Mailing address (if different) _____
5. Residential address at the time of the incident _____
6. Claimant's daytime telephone number: _____

INCIDENT INFORMATION

7. Date of incident _____ Time of incident _____ AM PM

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

From: _____ Time: _____ AM PM To: _____ Time: _____ AM PM

8. Describe the injury or damage sustained in this incident.

9. Describe the cause, conduct and / or circumstances that brought about the injury or damage.

10. Location of incident _____
State and County *City, if applicable* *Place where occurred*

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

12. Names, addresses and telephone numbers of all District employees having knowledge about this incident:

13. Names, addresses and telephone numbers of all individuals not already identified 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. Names, addresses and telephone numbers of treating medical providers.

15. The amount of damages claimed: _____
Please attach documents which support the claim's allegations (medical reports, accident reports, medical bills, etc.)

SIGNATURE

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 Forgoing is true and correct.

Signature

Date and place signed

Relationship to Claimant

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH
INFORMATION (PHI) TO
PUBLIC HOSPITAL DISTRICT NO. 1 OF SNOHOMISH COUNTY**
(D/B/A: VALLEY GENERAL HOSPITAL)

Name: _____

Date of birth: Month: _____ Day: _____ Year: _____

I hereby authorize disclosure of my protected health information to Public Hospital District No. 1 of Snohomish County (the District) (d/b/a Valley General Hospital), for purposes of processing my claim for damages.

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, 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.

(Continued)

I understand the following: *(Please read and initial all statements)*

(Initial)

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

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

_____ I understand that 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.

_____ I understand that I may revoke this authorization at any time by notifying the District in writing, and that the revocation will be effective as of the date the District 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 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 District.

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

Signature of Authorizing Individual

Date of Signature

Telephone Number

Witness (where patient if 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 (check those that apply and 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:

Norma Walker
Administration Executive Assistant
14701 179th Avenue SE
PO Box 646
Monroe, WA 98272

PUBLIC HOSPITAL DISTRICT NO. 1 OF SNOHOMISH COUNTY

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 & INCIDENT INFORMATION	Claimants Name (a separate form must be completed for each claimant)						Date of Incident (mm/dd/yyyy)		Time of Incident <input type="checkbox"/> AM <input type="checkbox"/> PM			
	Current Street Address (Residence)			City		State		Zip Code		Daytime Phone Number with Area Code		
	Location of Accident / Collision (address, street or highway, milepost number, etc.)						Intersection or Nearest Cross Street					
YOUR VEHICLE INFORMATION (Vehicle #1)	Year	Make	Model	License Plate #	Where can car be seen?			When?				
	Registered Vehicle Owner			Address				Daytime Phone Number with Area Code				
	Name of Driver			Address				Daytime Phone Number with Area Code				
	Driver's License #			State	Expiration Date	Auto Insurance Carrier		Policy Number				
	Describe Damage								Repair Estimate		\$	
OTHER VEHICLE INFORMATION (Vehicle #2)	Year	Make	Model	License Plate #	Where can car be seen?			When?				
	Registered Vehicle Owner			Address				Daytime Phone Number with Area Code				
	Name of Driver			Address				Daytime Phone Number with Area Code				
	Driver's License #			State	Expiration Date	Auto Insurance Carrier		Policy Number				
	Describe Damage								Repair Estimate		\$	
OTHER (NON-VEHICLE DAMAGE)	Was other (non-vehicle) property damaged? If yes, describe what type of property was damaged.											
	Name of Owner			Address				Daytime Phone Number with Area Code				
	Describe Damage								Repair Estimate		\$	
INJURED PARTIES	NAME		ADDRESS			DAYTIME PHONE		INJURY	AGE	VEH #	PED	OTHER
WITNESSES	NAME			ADDRESS				DAYTIME PHONE				

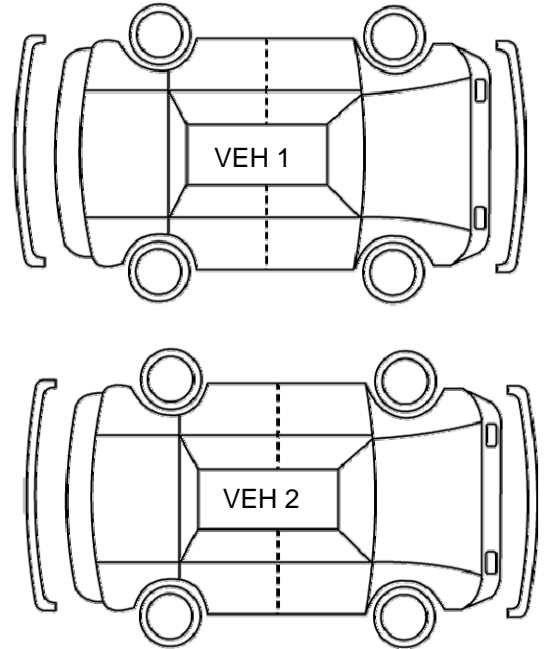
Describe conduct and circumstances causing injury or damages and explain the extent of medical, physical or mental injuries. Please identify name, address, and telephone number of treating physicians and other medical providers. Please attach property damage estimates and / or all medical bills in support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

- | | | |
|---|------------------------------------|--|
| <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 |

Indicate
N S E W
on
compass



Draw a diagram of the incident in the area below.



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

Light Conditions (check one)	Traffic Control	Type of Road (check one or more)	Vehicle Condition (check on or more)	Road Surface (check one)	Weather (check one)
<input type="checkbox"/> Daylight <input type="checkbox"/> Dawn <input type="checkbox"/> Dusk <input type="checkbox"/> Dark street, lights on <input type="checkbox"/> Dark street, lights off <input type="checkbox"/> Dark no street light <input type="checkbox"/> Other (specify)	Vehicle 1 2 <input type="checkbox"/> <input type="checkbox"/> Signals <input type="checkbox"/> <input type="checkbox"/> Stop sign <input type="checkbox"/> <input type="checkbox"/> Flashing red <input type="checkbox"/> <input type="checkbox"/> Flashing amber <input type="checkbox"/> <input type="checkbox"/> RR signal <input type="checkbox"/> <input type="checkbox"/> Officer / flagman <input type="checkbox"/> <input type="checkbox"/> Yield sign <input type="checkbox"/> <input type="checkbox"/> No traffic control <input type="checkbox"/> <input type="checkbox"/> Other (specify)	Vehicle 1 2 <input type="checkbox"/> <input type="checkbox"/> One way <input type="checkbox"/> <input type="checkbox"/> Two way <input type="checkbox"/> <input type="checkbox"/> Reversible road <input type="checkbox"/> <input type="checkbox"/> Interchanging loop ramp <input type="checkbox"/> <input type="checkbox"/> Alley <input type="checkbox"/> <input type="checkbox"/> Two way left turn lanes <input type="checkbox"/> <input type="checkbox"/> Separated <input type="checkbox"/> <input type="checkbox"/> Divided <input type="checkbox"/> <input type="checkbox"/> Undivided	Vehicle 1 2 <input type="checkbox"/> <input type="checkbox"/> Defective brakes <input type="checkbox"/> <input type="checkbox"/> Defective headlights <input type="checkbox"/> <input type="checkbox"/> Defective rear lights <input type="checkbox"/> <input type="checkbox"/> Tires worn <input type="checkbox"/> <input type="checkbox"/> Punctured or blown tire(s) <input type="checkbox"/> <input type="checkbox"/> Other	Vehicle 1 2 <input type="checkbox"/> <input type="checkbox"/> Dry <input type="checkbox"/> <input type="checkbox"/> Wet <input type="checkbox"/> <input type="checkbox"/> Snow <input type="checkbox"/> <input type="checkbox"/> Ice <input type="checkbox"/> <input type="checkbox"/> Other	<input type="checkbox"/> Clear, cloudy & overcast <input type="checkbox"/> Raining <input type="checkbox"/> Snowing <input type="checkbox"/> Fog <input type="checkbox"/> Other (specify)
				Name of investigating police agency:	
				Investigating agency report number:	

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 signed