COULEE MEDICAL CENTER

Douglas, Grant, Lincoln and Okanogan Counties Public Hospital District Number 6
411 Fortuyn Road, Grand Coulee, WA 99133-8718
Phone: 509-633-1753
Fax: 509-633-3644

Standard Tort Claim Packet

Instructions for completing a Standard Tort Claim form
General Liability Claim

- ✓ 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 claim form in binders or add tab dividers as all documents will 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 Standard Tort Claim Form for a general liability claim:

1. Smith, Karen Michelle – 02/20/65
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 – 206-987-6543
6. KMSmith@hotmail.com
7. 8/9/2010 0800 AM
8. If the incident occurred over a period of time, please provide the beginning and ending date and time.
9. Washington, Thurston, Tumwater, Campus of South Sound, Puget Sound Community College, Building number 22
10. I-5, Southbound, milepost 109, near Martin Way Exit
11. Smith, Thomas Arthur, 123 College Way NW Apt. 56, Seattle WA 98178 360-456-3456: Tow Truck Driver, Nisqually Towing

12. List names if known or write, Unknown.
13. List all 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 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 your medical providers names, addresses, telephone numbers and the type of treatment. If you were treated for a personal injury, please include your medical records and bills.
17. Please attach any additional documents that support your claim.
18. Please provide any dollar amount for your damages, including your time loss, medical costs, property damage loss, etc. This amount should represent your opinion of total compensation.
19. Sign the bottom of the form and complete the date and place you are signing from.

- ✓ If your claim involves a motor vehicle accident, please complete, sign and attach the motor vehicle accident form.

Once you have completed all needed forms, supplied any supporting documents and signed the forms you may either mail the document care of the administrator or hand deliver the document to the front desk of the hospital attention:

Agent for Claims
Administrator/Superintendent
Coulee Medical Center
Douglas, Grant, Lincoln and Okanogan Counties Public Hospital District #6
411 Fortuyn Road
Grand Coulee WA 99133

Hours are Monday - Friday 9:00 a.m. to 5:00 p.m.

If you have any questions regarding this process you may contact the hospital Risk Management department at 509-633-6333.

Standard Tort Claim Form

General Liability Claim Form

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

For Official Use only
No.

PLEASE TYPE OR PRINT IN INK

Mail or deliver original claim to:
Administrator/Superintendent
Coulee Medical Center
Douglas, Grant, Lincoln and Okanogan Counties
Public Hospital District Number 6
411 Fortuyn Road
Grand Coulee, WA 99133

Business Hours are 9AM to 5PM Monday - Friday

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: ____/____/_____ (mm/dd/yyyy) Time: _____ AM PM (circle one)
8. If the incident occurred over a period of time, date of first and last occurrences:
   from ____/____/_____ Time: _____ AM PM (circle one) to____/____/_____ Time _____ AM PM (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	____-____-____ Number	_____ Name	____-____-____ Number
_____ Name	____-____-____ Number	_____ Name	____-____-____ Number
_____ Name	____-____-____ Number	_____ Name	____-____-____ Number

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

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.

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.

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

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

17. Please attach documents which support the claim's allegations.

18. I claim damages from Public Hospital District Number 6 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.

Signature of Claimant

Date and place (residential address, city and 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 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

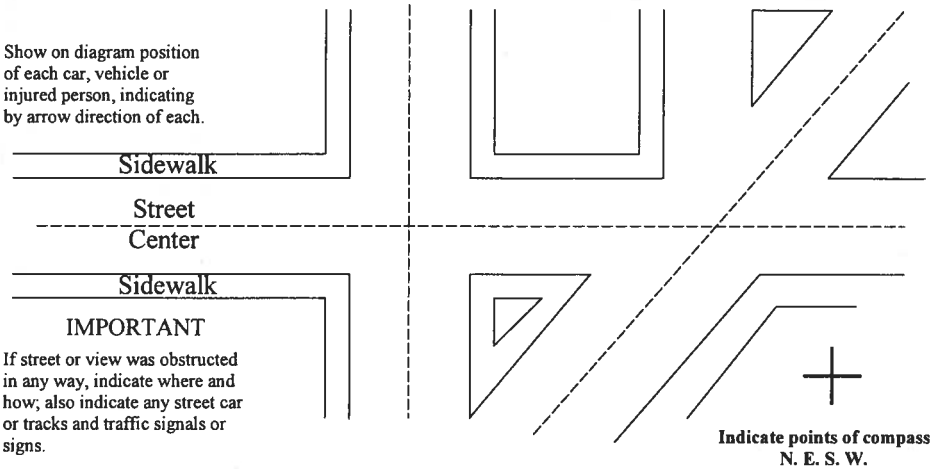
Describe conduct and circumstances causing injury or damages and explain the extent of medical, physical or mental injuries. Please identify name, address, and telephone number of treating physicians and other medical providers. Please attach property damage estimates and/or all medical bills in support 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.

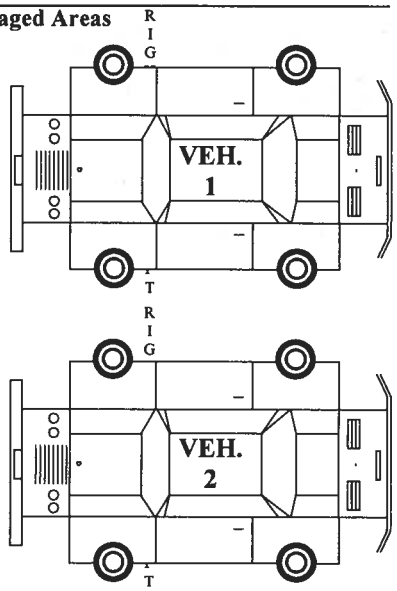


IMPORTANT

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	
4 ☐ DARK STREET LIGHTS ON	☐ ☐ 3 FLASHING RED	☐ ☐ 3 REVERSIBLE ROAD	☐ ☐ 3 DEFECTIVE REAR LIGHTS	☐ ☐ 3 SNOW	3 ☐ SNOWING
5 ☐ DARK STREET LIGHTS OFF	☐ ☐ 4 FLASHING AMBER	☐ ☐ 4 INTER-CHANGE LOOP RAMP	☐ ☐ 4 TIRES WORN	☐ ☐ 4 ICE	4 ☐ FOG
6 ☐ DARK NO STREET LIGHT	☐ ☐ 5 RR SIGNAL	☐ ☐ 5 ALLEY	☐ ☐ 5 PUNCTURED OR BLOWN TIRES	☐ ☐ 5 OTHER (SPECIFY)	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)*