PORT OF COUPEVILLE

ISLAND COUNTY, WASHINGTON
RESOLUTION NO. 232

A RESOLUTION of the Board of Commissioners of the Port of Coupeville, Island County, Washington, appointing a Claims Agent

WHEREAS, the Port of Coupeville is a special purpose district established under the laws of the State of Washington

WHEREAS, the Revised Code of Washington (RCW) 4.96.020 requires that "The governing body of each local governmental entity shall appoint an agent to receive any claim for damages made under this chapter. The identity of the agent and the address where he or she may be reached during the normal business hours of the local governmental entity are public records and shall be recorded with the auditor of the county in which the entity is located."

WHEREAS, the Board of Commissioners desires to assign the function of Claims Agent to the Port of Coupeville Executive Director as part of that position's collateral delegated administerial powers and duties.

NOW THEREFORE, BE IT RESOLVED by the Board of Commissioners of the Port of Coupeville, Island County, Washington that the Port of Coupeville Executive Director is appointed Claims Agent.

- The Executive Director may be reached during the normal business hours of the Port of Coupeville through the Port Office at Greenbank Farm at 765 Wonn Road, Greenbank, Washington or by telephone at (360) 222-3151.

- This appointment shall be recorded with the Island County Auditor's Office in accordance with RCW 4.96.020.

- Port of Coupeville Resolution 212 is hereby rescinded.

All claims for damages against the Port of Coupeville, or against any officers, employees, or volunteers, acting in such capacity, shall be presented to the agent within the applicable period of limitations within which an action must be commenced. A claim is deemed presented when the claim form is delivered in person or is received by the agent by regular mail, registered mail, or certified mail, with return receipt requested, to the agent or other person designated to accept delivery at the agent's office.

ADOPTED by the Board of Commissioners of the Port of Coupeville at the public meeting thereof held this 12th day of April, 2017 and duly authenticated in open session by the signatures of the Commissioners being present and voting.

William Bell | John Mishasek | Robert Monroig

Attest: This 12th day of April, 2017

INSTRUCTIONS FOR COMPLETING A TORT CLAIM FORM

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 in claim form in binders or add divider tabs as all documents must 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.

If you are filing a personal injury claim please sign and attach the Medical Release

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

Submit the Tort Claim Form and Supporting Documents by mail, fax, or email to:

Port of Coupeville Executive Director
PO Box 128
Greenbank, WA 98253

or FAX to 360-222-3484

or Email to executivedirector@portofcoupeville.org

STANDARD TORT CLAIM FORM

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against the Port of Coupeville. Some of the information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure.

PLEASE TYPE OR PRINT CLEARLY IN INK

Mail or deliver original claim to

Port of Coupeville Executive Director
PO Box 128
Greenbank, WA 98253

or FAX to 360-222-3484

or Email to executivedirector@portofcoupeville.org

Business Hours: Monday – Friday 8:00 a.m. to 4:00 p.m.
Closed on weekends and official state holidays.

1. Claimant's name: _____
   Last name First Middle Date of birth (mm/dd/yyyy)

2. Inmate DOC number (if applicable): _____

3. Current residential address: _____

4. Mailing address (if different): _____

5. Residential address at the time of the incident: _____
   (if different from current address)

6. Claimant's daytime telephone number: _____ _____
   Home Business or Cell

7. Claimant's e-mail address: _____

8. Date of the incident: _____ Time:_____ ☐ a.m. ☐ p.m. (check one)
   (mm/dd/yyyy)

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

   from _____ Time: _____ ☐ a.m. ☐ p.m.
   (mm/dd/yyyy) (mm/dd/yyyy)

   to _____ Time:_____ ☐ a.m. ☐ p.m.
   (mm/dd/yyyy) (mm/dd/yyyy)

10. Location of incident: _____
    State and county City, if applicable Place where occurred

11. If the incident occurred on a street or highway:

Name of street or highway	Milepost number	At the intersection with or nearest intersecting street

12. State agency or department alleged responsible for damage/injury:

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

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

15. Names, addresses and telephone numbers of all individuals not already identified in #13 and #14 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.

16. 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.

17. Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom? Please attach a copy of the report or contact information.

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

19. Please attach documents which support the allegations of the claim.

20. I claim damages from the state of Washington 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.

_____ _____

Signature of Claimant ***Date and place (residential address, city and county)***

Or

_____ _____

Signature of Representative ***Date and place (residential address, city and county)***

_____ _____

Print Name of Representative ***Bar Number (if applicable)***

Authorization for Release of Protected Health Information (PHI)

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 Department of Enterprise Services, Office of Risk Management (Risk Management) 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 of treatment records

Pharmacy prescriptions and reports

All letters and memos received or sent, including electronic mail, referencing my treatment, compliance with treatment and any other subject related to my medical 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

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 Risk Management and not protected for purposes of evaluating and investigating the claim I have filed with the state of 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 Risk Management in writing, and that the revocation will be effective as of the date Risk Management 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 RMD.

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

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

_____

To the Provider or Records Custodian:

Please send legible copies of all records to:

Port of Coupeville Executive Director
PO Box 128
Greenbank, WA 98253
or FAX to 360-222-3484
or Email to executivedirector@portofcoupeville.org

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.

_____

_____

_____

_____

_____

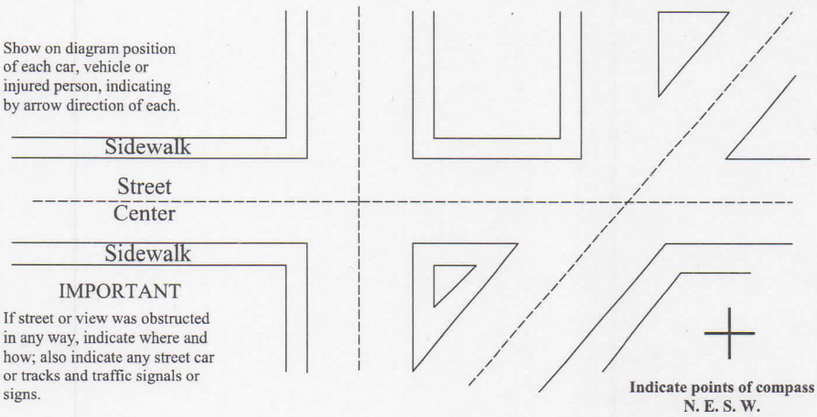
_____

☐ 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.

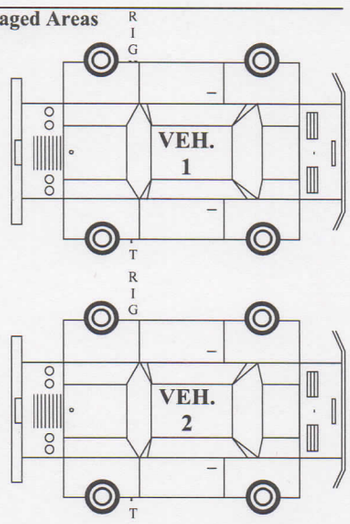


IMPORTANT

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	3 ☐ SNOWING
4 ☐ DARK STREET LIGHTS ON	☐ 3 ☐ FLASHING RED	☐ 3 ☐ REVERSIBLE ROAD	☐ 3 ☐ DEFECTIVE REAR LIGHTS	☐ 3 ☐ SNOW	4 ☐ FOG
5 ☐ DARK STREET LIGHTS OFF	☐ 4 ☐ FLASHING AMBER	☐ 4 ☐ INTER-CHANGE LOOP RAMP	☐ 4 ☐ TIRES WORN	☐ 4 ☐ ICE	5 ☐ OTHER (SPECIFY)
6 ☐ DARK NO STREET LIGHT	☐ 5 ☐ RR SIGNAL	☐ 5 ☐ ALLEY	☐ 5 ☐ PUNCTURED OR BLOWN TIRES	☐ 5 ☐ OTHER (SPECIFY)	
7 ☐ OTHER (SPECIFY)	☐ 6 ☐ OFFICER/ FLAGMAN	☐ 6 ☐ TWO WAY-LEFT TURN LANES	☐ 6 ☐ OTHER (SPECIFY)		
	☐ 7 ☐ YIELD SIGN	☐ 1 ☐ SEPARATED			
	☐ 8 ☐ NO TRAFFIC CONTROL	☐ 2 ☐ DIVIDED			
	☐ 9 ☐ OTHER	☐ 3 ☐ UNDIVIDED			

NAME OF INVESTIGATING POLICE AGENCY:

_____

INVESTIGATING AGENCY REPORT NO.

_____

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)***