

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
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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)**

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

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

_____ I understand that the specific information to be disclosed in my medical record may include
Initials 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 Risk Management in
Initials 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.

_____ I understand that this Authorization for Release will expire 90 days from the date I sign it. I can
Initials 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

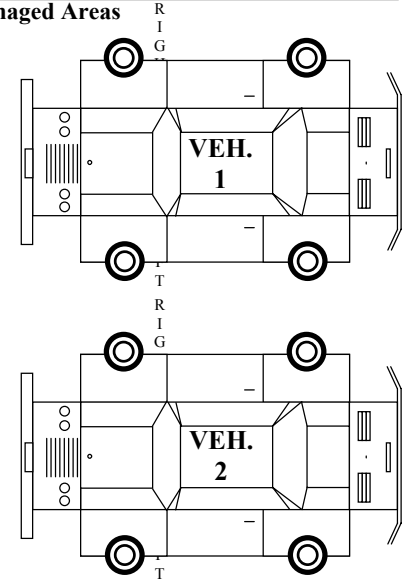
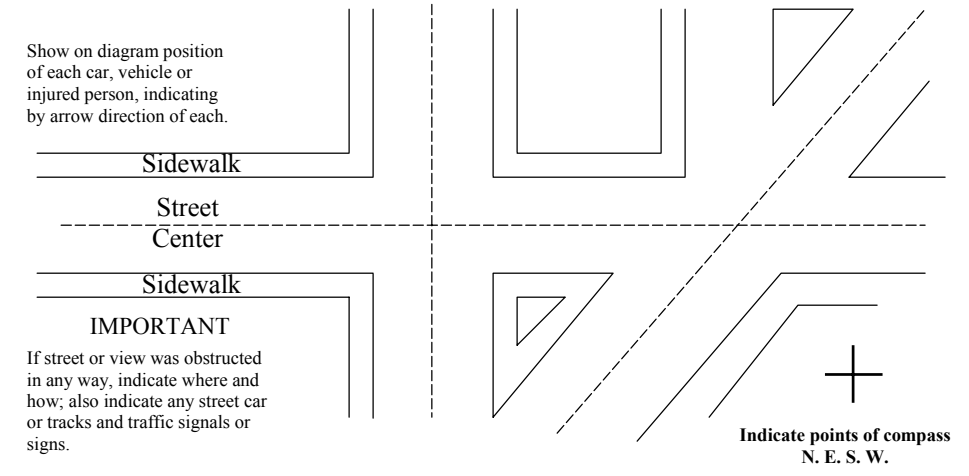
Please attach this form to your standard tort claim form, if the claim involves a vehicle collision.

CLAIMANT AND INCIDENT INFORMATION	CLAIMANT'S NAME (A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)				DATE OF ACCIDENT(mm/dd/yyyy)			TIME AM <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 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.

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



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 <input type="checkbox"/> 1 <input type="checkbox"/> SIGNALS	VEHICLE NO. 1 NO. 2 <input type="checkbox"/> 1 <input type="checkbox"/> ONE WAY	VEHICLE NO. 1 NO. 2 <input type="checkbox"/> 1 <input type="checkbox"/> DEFECTIVE BRAKES	VEHICLE NO. 1 NO. 2 <input type="checkbox"/> 1 <input type="checkbox"/> DRY	1 <input type="checkbox"/> CLEAR, CLOUDY & OVERCAST
2 <input type="checkbox"/> DAWN	<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	2 <input type="checkbox"/> RAINING
3 <input type="checkbox"/> DUSK	<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	3 <input type="checkbox"/> SNOWING
4 <input type="checkbox"/> DARK STREET LIGHTS ON	<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	4 <input type="checkbox"/> FOG
5 <input type="checkbox"/> DARK STREET LIGHTS OFF	<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)	5 <input type="checkbox"/> OTHER (SPECIFY)
6 <input type="checkbox"/> DARK NO STREET LIGHT	<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)	NAME OF INVESTIGATING POLICE AGENCY: _____ INVESTIGATING AGENCY REPORT NO. _____	
7 <input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> 7 <input type="checkbox"/> YIELD SIGN	<input type="checkbox"/> 1 <input type="checkbox"/> SEPARATED			
	<input type="checkbox"/> 8 <input type="checkbox"/> NO TRAFFIC CONTROL	<input type="checkbox"/> 2 <input type="checkbox"/> DIVIDED			
	<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)