Standard Tort Claim Form Packet

Please *carefully read all of the information in this packet* before completing and submitting your Standard Tort Claim. Please note that no documents will be returned.

Presenting a Standard Tort Claim Form

RCW 4.92.100 requires citizens to present the Standard Tort Claim form with the Office of Risk Management (ORM). The law also requires ORM to post on its website the Standard Tort Claim form with instructions. In compliance with these requirements and for the convenience of citizens, ORM 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 (SF 210)
3. Medical Authorization
4. Vehicle Collision Form only for tort claims involving vehicle accidents/collisions
5. Mandatory Medicare Beneficiary Reporting Form

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

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

Grays Harbor County Public Hospital District No. 1
Dba Summit Pacific Medical Center
Josh Martin, Superintendent or his Executive Assistant, Jori Smith
600 East Main Street
Elma, WA 98541

Business Hours: Monday-Friday, 8:00 a.m. to 5:00 p.m. Closed on weekends and official state holidays.

INSTRUCTIONS FOR COMPLETING A TORT CLAIM FORM
General Liability Claim Form #SF 210

- ❑ 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.
- ❑ The following are examples on how to complete the Tort Claim Form #SF 210:

1. Smith, Karen Michelle – 02/20/1965
2. 1114 W Main Street, Elma, Apartment 15, Elma WA 98541
3. PO Box 910, Elma WA 98541
4. Same (or residence at the time of incident)
5. (360) 123-4567 – (360) 987-6543
6. KMSmith@hotmail.com
7. 8/9/2010 8:00 a.m.
8. If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item 8.
9. Washington, Grays Harbor, Campus of Summit Pacific Medical Center, Parking Lot
10. If the incident occurred on a street or highway
11. Employee or Department name
12. Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Seattle WA 98178 (360) 456-3456; EMS Driver
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 10 and 11. 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 the injury or damages, specifically answering the questions who, what, where, when and why.
15. Describe the cause of the injury or damages.
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 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.
18. Please attach any additional documents that support your claim.
19. 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 your claim involves a motor vehicle accident, please complete, sign and attach the Vehicle Collision Form.. .

STANDARD TORT CLAIM FORM
General Liability Claim Form #SF 210

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against Grays Harbor County Public Hospital District No. 1, dba Summit Pacific Medical Center & Clinics. 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 (via e-mail or fax)

PLEASE TYPE OR PRINT CLEARLY IN INK

Mail or deliver original claim to:
Grays Harbor County Public Hospital District No. 1
dba Summit Pacific Medical Center
Josh Martin, Superintendent
or his Executive Assistant, Jori Smith
600 East Main Street
Elma, WA 98541

Business Hours: Monday – Friday 8:00am – 5:00pm
Closed on weekends and official state holidays

THE STANDARD TORT CLAIM FORM IS NOT TO BE USED FOR CLAIMS INVOLVING INJURIES FROM HEALTH CARE. SUCH CLAIMS ARE GOVERNED BY CHAPTER 7.70 RCW.

CLAIMANT INFORMATION:

1. Claimant's name: _____
   Last First Middle Date of birth
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 incident: _____
   State & County City (if applicable) Place where occurred
8. If the incident occurred over a period of time, date of first and last occurrences:
   From _____time: ____ __.m to _____ time: ____ __.m.
9. Location of incident: : _____
   State & county City (if applicable) Place where occurred
10. If the incident occurred on a street or highway:

    _____

Name of street/highway Milepost no. Nearest intersecting street

11. Person or department alleged responsible for damage/injury:

_____

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

_____

_____

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 10 and 11. Also include a description of their knowledge.

_____

_____

_____

14. Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where and why.

_____

_____

_____

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.

_____

_____

_____

16. 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.

_____

_____

_____

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

_____

_____

_____

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

19. I claim damages from Grays Harbor County Public Hospital District No. 1 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 & county)

Or

_____ _____

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

_____ _____

Print Name of Representative Bar Number (if applicable)