

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 the state of Washington. Some of the information requested on this form is required by RCW 4.92.100 and may be subject to public disclosure.

PLEASE TYPE OR PRINT CLEARLY IN INK

Mail or deliver original claim to Puget Sound Educational Service District
Superintendent
800 Oakesdale Ave. SW
Renton, WA 98057
Phone: 425-917-7600
Fax: 425-917-7777



Business Hours: Monday – Friday 7:30 a.m. – 4:30 p.m.
Closed on weekends and official state holidays.

1. Claimant's name: _____

Last name	First	Middle	Date of birth (mm/dd/yyyy)
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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
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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: _____	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
(mm/dd/yyyy)	(mm/dd/yyyy)	
to _____		
(mm/dd/yyyy)	Time: _____	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
(mm/dd/yyyy)	(mm/dd/yyyy)	
10. Location of incident: _____

State and county	City, if applicable	Place where occurred
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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)