

Standard Tort Claim Form Packet

Please *carefully read all of the information in this packet* before completing and presenting your Standard Tort Claim.

A New Law that Impacts Presenting a Standard Tort Claim Form

Engrossed Substitute House Bill 1553, effective July 26, 2009, requires citizens to present the Standard Tort Claim form with the government agency named in their claim. The law also requires State and local government agencies to post the Standard Tort Claim form on their websites with instructions on how to complete the form. In compliance with these requirements and for the convenience of citizens, The State Office of Financial Management (OFM) 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 (SF-210)
2. Standard Tort Claim Form (SF 210)
3. Medical Authorization
4. Vehicle Collision Form (for tort claims involving vehicle accidents/collisions)

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

Present in Person or Mail the Standard Tort Claim Form and Supporting Documents to:

Issaquah School District #411
Attn: Risk Management
5150 220th Ave SE
Issaquah, WA 98029

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

INSTRUCTIONS FOR COMPLETING A STANDARD TORT CLAIM FORM #SF 210

- Before presenting a Standard Tort Claim form, please read these instructions, the Standard Tort Claim form, and other appropriate forms in their entirety.
- Type or print clearly in ink and sign the Standard Tort Claim form.
- 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 Standard Tort Claim form can be easily read and understood.
- The following are examples on how to complete the Standard Tort Claim Form (#SF 210):
 1. Smith, Karen Michelle
 2. 1234 College Way NW, Apt. 56, Issaquah, WA 98027
 3. PO Box 910, Issaquah, WA 98027
 4. Same (or residence at the time of incident)
 5. 425-123-4567
 6. KarenS@aol.com
 7. 8:00 a.m., August 9, 2008
 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 7
 9. Washington, King, Issaquah, Issaquah High School, Room 123 Building number A
 10. If applicable, I-90, Eastbound, Milepost 10, near the Front Street Exit
 11. Issaquah School District
 12. Smith, Thomas Arthur, 1234 College Way NW, Apt. 56 Issaquah, WA 98027
(425) 456-3456
 13. List employee names if known or enter "Unknown"
 14. List all other 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.
 15. 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.
 16. Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.
 17. 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.
 18. 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 you are presenting a personal injury claim, please sign and attach the Medical Release form.
- If your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision Form.

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

14. Names, addresses and telephone numbers of all individuals not already identified in #12 and #13 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.

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?

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 claim's allegations.

19. I claim damages from the Issaquah School District 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)

Claim # _____

**Authorization for Release of Protected Health Information (PHI)
To
Issaquah School District, attn: Risk Management**

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 Issaquah School District, 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. 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 Washington State Health Care Information Act (RCW 70.02).

_____ I understand that my health information may be subject to re-disclosure by Issaquah School District #411 and 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 Issaquah School District in writing, and that the revocation will be effective as of the date Issaquah School District 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 also authorize a different time frame for this release to be valid. This permission is valid until my claim is resolved or closed by Issaquah School District #411.

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to Issaquah School District

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):

- | | |
|--|---|
| <input type="checkbox"/> Parent of minor | <input type="checkbox"/> Legal Guardian |
| <input type="checkbox"/> Personal Representative | <input type="checkbox"/> Other |

To the Provider or Records Custodian:

Please send legible copies of all records to:

Issaquah School District
Attn: Risk Management
5150 220th Ave SE
Issaquah, WA 98029

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 \$						
	WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.										
OTHER NON-VEHICLE DAMAGE	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"/> Curve – R or L <input type="checkbox"/> Level	<input type="checkbox"/> Hillcrest <input type="checkbox"/> Uphill <input type="checkbox"/> Downhill	<input type="checkbox"/> One Lane <input type="checkbox"/> One and One-Half Lane <input type="checkbox"/> Two Lane or Four Lane
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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.

Mark Damaged Areas

Indicate points of compass
N. E. S. W.

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 1 <input type="checkbox"/> SIGNALS	VEHICLE NO. 1 NO. 2 1 <input type="checkbox"/> ONE WAY	VEHICLE NO. 1 NO. 2 1 <input type="checkbox"/> DEFECTIVE BRAKES	VEHICLE NO. 1 NO. 2 1 <input type="checkbox"/> DRY	1 <input type="checkbox"/> CLEAR, CLOUDY & OVERCAST
2 <input type="checkbox"/> DAWN	2 <input type="checkbox"/> STOP SIGN	2 <input type="checkbox"/> TWO WAY	2 <input type="checkbox"/> DEFECTIVE HEADLIGHTS	2 <input type="checkbox"/> WET	2 <input type="checkbox"/> RAINING
3 <input type="checkbox"/> DUSK	3 <input type="checkbox"/> FLASHING RED	3 <input type="checkbox"/> REVERSIBLE ROAD	3 <input type="checkbox"/> DEFECTIVE REAR LIGHTS	3 <input type="checkbox"/> SNOW	3 <input type="checkbox"/> SNOWING
4 <input type="checkbox"/> DARK STREET LIGHTS ON	4 <input type="checkbox"/> FLASHING AMBER	4 <input type="checkbox"/> INTER-CHANGE LOOP RAMP	4 <input type="checkbox"/> TIRES WORN	4 <input type="checkbox"/> ICE	4 <input type="checkbox"/> FOG
5 <input type="checkbox"/> DARK STREET LIGHTS OFF	5 <input type="checkbox"/> RR SIGNAL	5 <input type="checkbox"/> ALLEY	5 <input type="checkbox"/> PUNCTURED OR BLOWN TIRES	5 <input type="checkbox"/> OTHER (SPECIFY)	5 <input type="checkbox"/> OTHER (SPECIFY)
6 <input type="checkbox"/> DARK NO STREET LIGHT	6 <input type="checkbox"/> OFFICER/FLAGMAN	6 <input type="checkbox"/> TWO WAY-LEFT TURN LANES	6 <input type="checkbox"/> OTHER (SPECIFY)	NAME OF INVESTIGATING POLICE AGENCY: _____ INVESTIGATING AGENCY REPORT NO. _____	
7 <input type="checkbox"/> OTHER (SPECIFY)	7 <input type="checkbox"/> YIELD SIGN	1 <input type="checkbox"/> SEPARATED			
	8 <input type="checkbox"/> NO TRAFFIC CONTROL	2 <input type="checkbox"/> DIVIDED			
	9 <input type="checkbox"/> OTHER	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)