Chimacum School District

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 Chimacum School District (CSD) Risk Management Department (RMD). The law also requires CSD - RMD to post on its website the Standard Tort Claim form with instructions. In compliance with these requirements and for the convenience of citizens, the Risk Management Department 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

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:

Chimacum School District
PO Box 278 (91 West Valley Rd)
Chimacum WA 98325
Attn: Risk Management Department

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

July 2009

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 is an example on how to complete the Standard Tort Claim Form (#SF 210):

1. Smith, Karen Michelle
2. 1234 College Way NW, Apt. 56, Seattle WA 98178
3. PO Box 910, Seattle WA 98178
4. Same (or residence at the time of incident)
5. 206-123-4567
6. 8:00 a.m., August 9, 2008
7. 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
8. Washington, Thurston, Tumwater, Campus of South Puget Sound Community College, Building number 22
9. I-5, Southbound, Milepost 109, near the Martin Way Exit
10. Washington State Department of Transportation, Highway
11. Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Seattle WA 98178 (360) 456-3456; Tow Truck Driver, Nisqually Towing
12. Unknown
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 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.
14. 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.
15. Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.
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 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.
18. If you are presenting a personal injury claim, please sign and attach the Medical Release form.
19. If your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision Form.

CHIMACUM SCHOOL DISTRICT 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. Pursuant to the new law, Standard Tort Claim forms cannot be submitted electronically (via e-mail or fax).

PLEASE TYPE OR PRINT IN INK

Mail or deliver to: Chimacum School District, PO Box 278 (91 West Valley Rd) Chimacum WA 98325 Attn: Risk Management Department

CLAIMANT INFORMATION

1. Claimant's name: Last name, First Name, Middle Initial		Date of birth (mm/dd/yyyy)
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 phone number:	Home phone number	Business or cell phone number
6. Claimant's email address:		

INCIDENT INFORMATION

7. Date of incident: (mm/dd/yyyy)	Time: (indicate AM or PM)	
8. If the incident occurred over a period of time, date of first and last occurrences: From:_____ Time:_____ AM or PM To:_____ Time:_____ AM or PM		
9. Location of incident: below		
state and county	city if applicable	place where occurred
10. If the incident occurred on a street or highway:		
Name of street or highway	Milepost number	At the intersection with or nearest intersecting street
11. State agency or department alleged responsible for damage/injury:		
12. Names, addresses and telephone number of all persons involved in or witness to this incident:		
13. Names, addresses and telephone number 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 the incident been reported to law enforcement, safety or security personnel? If so, when and to whom?
17. Names, addresses and telephone number 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 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)

Claim# _____

Authorization for Release of Protected Health Information (PHI) to the Chimacum School District Risk Management Department

Name: Last, First, Middle	Date of Birth:

I hereby authorize disclosure of my protected health information to the Chimacum School District Risk Management Department 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 Initials Washington State Health Care Information Act (RCW 70.02).

(PLEASE READ AND INITIAL ALL STATEMENTS)

_____I understand that my health information may be subject to re-disclosure by Chimacum School District Risk Management Department and not Initials 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 Chimacum School District Risk Management Department in writing, and that Initials the revocation will be effective as of the date Chimacum School District Risk Management Department 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 the Chimacum School District Risk Management Department.

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

_____

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:

Chimacum School District
PO Box 278 (91 West Valley Rd)
Chimacum WA 98325
Attn: Risk Management Department