Standard Tort Claim Form

Washington State law (Chapter 4.96 RCW) requires a Standard Tort Claim Form to be submitted when filing a tort claim against the Bellevue School District. Standard Tort Claim forms cannot be submitted electronically (via e-mail or fax) but must be mailed or delivered to the address noted in the forms packet. Please read all of the information in the packet before completing and presenting your Standard Tort Claim.

The District requires all individuals to present the Standard Tort Claim form to the Business Services Department at the address listed below. This packet is designed for the convenience of our citizens and in accordance with the law.

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:

Bellevue School District
Attn: Superintendent's Office
12111 N.E. 1st Street
Bellevue, WA 98005

Business Hours: Monday through Friday 8:00 a.m. to 4:30 p.m.
Closed on weekends and 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.

./ 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
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, 2004
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

./ 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.

STANDARD TORT CLAIM FORM

General Liability Claim Form #SF 210

For Official Use Only

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against the Bellevue School District. Some of the information requested on this form is required by RCW 4.96 and may be subject to public disclosure. Pursuant to the law, Standard Tort Claim forms cannot be submitted electronically (via email or fax).

PLEASE TYPE OR PRINT IN INK

Mail or deliver original claim

Bellevue School District
Attn: Superintendent's Office
12111 N.E. 1st Street
Bellevue, WA 98005

Business Hours: Monday - Friday 8:00 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)

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: ______________________________

7. Date of the incident: ______________ Time: ______ O a.m. O p.m. (check one)
   (mm/dd/yyyy)

8. If the incident occurred over a period of time, date of first and last occurrences:

   from ______________________ Time: ____________ O a.m. O p.m.
   (mm/dd/yyyy) (mm/dd/yyyy)

   to ______________________ Time: ____________ O a.m. O p.m.
   (mm/dd/yyyy) (mm/dd/yyyy)

9. Location of incident: ______________________________
   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. Department alleged responsible for damage/injury:

____

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

____
____
____

13. Names, addresses and telephone numbers of all BSD 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.

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18. Please attach documents which support the claim's allegations.

19. I claim damages from the Bellevue 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)***

Authorization for Release of Protected Health Information (PHI)
to
The Bellevue School District - Risk Management Division

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 Bellevue School District, Risk Management Division, for purposes of processing my claim for damages filed with the Bellevue School District.

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 Washington State Health Care Information Act (RCW 70.02).
Initials

______ I understand that my health information may be subject to re-disclosure by Bellevue School District and not protected for purposes of evaluating and investigating the claim I have filed with the Bellevue School District.
Initials

______ I understand that the specific information to be disclosed in my medical record may include information regarding alcohol, drug or other controlled substance use, counseling referrals and/or a history of testing or treatment of acquired immune deficiency syndrome.
Initials

______ I understand that I may revoke this authorization at any time by notifying Bellevue School District in writing, and that the revocation will be effective as of the date Bellevue 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.
Initials

______ 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 Bellevue School District.
Initials

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to Bellevue 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):

- D Parent of minor
- D Legal Guardian
- D Personal Representative
- D Other

To the Provider or Records Custodian:

Please send legible copies of all records to:

Bellevue School District
Attn:
Superintendent's Office
12111 N.E. 1st Street
Bellevue, WA 98005