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

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against Union Gap School District No. 2. Some of the information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure. Pursuant to the new law, Standard Tort Claim forms cannot be submitted electronically (neither email nor fax). The law also requires Union Gap School District to post on its website the Standard Tort Claim form with instructions. In compliance with these requirements and for the convenience of citizens, Union Gap School District 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:

Union Gap School District
Lisa Gredvig, Superintendent
3201 South 4th Street
Union Gap, WA 98903

Business Hours: Monday-Friday, 8:00 a.m.-4:00 p.m.
Closed Official State Holidays and Weekends
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 of how to complete the Standard Tort Claim Form (#SF 210):
  Smith, Karen Michelle
  1234 College Way NW, Apt. 56, Seattle WA 98178
  PO Box 910, Seattle WA 98178
  Same (or residence at the time of incident)
  206-123-4567
  8:00 a.m., August 9, 2008
  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
  Washington, Thurston, Tumwater, Campus of South Puget Sound Community College, Building number 22
  I-5, Southbound, Milepost 109, near the Martin Way Exit
  Washington State Department of Transportation, Highway
  Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Seattle WA 98178 (360) 456-3456; Tow Truck Driver,
  Nisqually Towing
  Unknown

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.

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.

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

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.

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.
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 Union Gap School District. 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
Union Gap School District
Lisa Gredvig, Superintendent
3201 South 4th Street
Union Gap, WA 98903

Business Hours: Mon.- Fri. 8:00 a.m.- 4:00 p.m. Closed on weekends and official state holidays.

CLAIMANT INFORMATION:
1. 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 telephone number:
   Home__________________________ Business________________________

6. Claimant’s email address:

INCIDENT INFORMATION:
7. Date of the incident: ________________ Time: ______ a.m. ______ p.m. ______

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

9. Location of incident: (State and County, City, of applicable; Place where occurred)

10. If the incident occurred on a street or highway, provide information on nearest or intersecting streets:

11. State agency or 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 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 that support the claim's allegations.

19. I claim damages from the Union Gap 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

Union Gap School District
3201 South 4th Street
Union Gap, WA 98903

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 Union Gap School District, for purposes of processing my claim for damages filed with the Union Gap 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, 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 Union Gap School District and not protected for purposes of evaluating and investigating the claim I have filed with the Union Gap School District.

_____ 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.

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

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

• Parent of minor
• Legal Guardian
• Personal Representative
• Other

To the Provider or Records Custodian
Please send legible copies of all records to:
Union Gap School District
Lisa Gredvig, Superintendent
3201 South 4th Street
Union Gap, WA 98903

2
Please attach this form to your standard tort claim form, if the claim involves a vehicle collision.

<table>
<thead>
<tr>
<th>Claimant's Name</th>
<th>(A separate form must be completed for each claimant)</th>
<th>Date of Accident (mm/dd/yyyy)</th>
<th>Time AM ☐ PM ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Street (Residence) Address</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>(Residence) Street Address for Six Months Prior to the Accident</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>State/County/City (if applicable) where occurred</td>
<td>Street or Hwy</td>
<td>Milepost No.</td>
<td>Intersection or Nearest Street/Road</td>
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<tr>
<td>Year</td>
<td>Make</td>
<td>Model</td>
<td>License Plate No.</td>
</tr>
<tr>
<td>Name of Vehicle Owner</td>
<td>Address</td>
<td>City</td>
<td>Home and Work Phone</td>
</tr>
<tr>
<td>Name of Driver</td>
<td>Address</td>
<td>City</td>
<td>Home and Work Phone</td>
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<tr>
<td>Driver's License Number</td>
<td>State of Issuance</td>
<td>Date of Expiration</td>
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<tr>
<td>Describe Damage</td>
<td>Estimate $</td>
<td>Your Insurance Company and Policy No.</td>
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<tr>
<td>Year</td>
<td>Make</td>
<td>Model</td>
<td>License Plate No.</td>
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<tr>
<td>Name of Owner</td>
<td>Address</td>
<td>City</td>
<td>Phone</td>
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<tr>
<td>Name of Driver</td>
<td>Address</td>
<td>City</td>
<td>Phone</td>
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<tr>
<td>Describe Damage</td>
<td>Estimate $</td>
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<tr>
<td>Was Other (Non-Vehicle) Property Damaged? If so, describe what type of property was damaged.</td>
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<tr>
<td>Name of Owner</td>
<td>Address</td>
<td>City</td>
<td>Phone</td>
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<tr>
<td>Describe Damage</td>
<td>Estimate $</td>
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<td>Name (Attach Additional Sheets If Necessary)</td>
<td>Address</td>
<td>City</td>
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<td>Home</td>
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</tbody>
</table>

SF 138 (July 2009)
**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.

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<table>
<thead>
<tr>
<th>LIGHT CONDITIONS (CHECK ONE)</th>
<th>TRAFFIC CONTROL</th>
<th>TYPE OF ROAD (CHECK ONE OR MORE)</th>
<th>VEHICLE CONDITION (CHECK ONE OR MORE)</th>
<th>ROAD SURFACE (CHECK ONE)</th>
<th>WEATHER (CHECK ONE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>DAYLIGHT</td>
<td>VEHICLE NO. 1</td>
<td>VEHICLE NO. 1</td>
<td>VEHICLE NO. 1</td>
<td>VEHICLE NO. 1</td>
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<td>2</td>
<td>DAWN</td>
<td>SIGNALS</td>
<td>ONE WAY</td>
<td>DEFECTIVE BRAKES</td>
<td>DRY</td>
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<td>3</td>
<td>DUSK</td>
<td>STOP SIGN</td>
<td>TWO WAY</td>
<td>DEFECTIVE HEADLIGHTS</td>
<td>1</td>
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<td>4</td>
<td>DARK STREET LIGHTS ON</td>
<td>FLASHING RED</td>
<td>INTER-CHANGE LOOP RAMP</td>
<td>REAR LIGHTS</td>
<td>2</td>
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<td>5</td>
<td>DARK STREET LIGHTS OFF</td>
<td>FLASHING AMBER</td>
<td>ALLEY</td>
<td>TIRES WORN</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>DARK NO STREET LIGHT</td>
<td>RR SIGNAL</td>
<td>TWO WAY-LEFT TURN LINES</td>
<td>SEPARATED</td>
<td>4</td>
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<td>7</td>
<td>OTHER (SPECIFY)</td>
<td>OFFICER/FLAGMAN</td>
<td>DEFECTIVE BRAKES</td>
<td>LANE</td>
<td>5</td>
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<td>8</td>
<td></td>
<td>YIELD SIGN</td>
<td>DEFECTIVE HEADLIGHTS</td>
<td>1</td>
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<td>9</td>
<td></td>
<td>NO TRAFFIC CONTROL</td>
<td>DEFECTIVE REAR LIGHTS</td>
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<td></td>
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<td>OTHER</td>
<td>TIRES WORN</td>
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<td>SEPARATED</td>
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<td>DIVIDED</td>
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<td>UNDIVIDED</td>
<td>6</td>
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</tbody>
</table>

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)**