

# Standard Tort Claim Form Packet

## (Island County)

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

### Presenting a Standard Tort Claim Form

All claims against the county, or against the county's officers, employees, or volunteers, must be presented on the Standard Tort Claim Form (Island County) to the office of Risk Management.

### Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Tort Claim Form
2. Standard Tort Claim Form
3. Authorization for Release of Protected Health Information (PHI) only for tort claims involving personal injuries
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, by Mail or Email the Standard Tort Claim Form and Supporting Documents to:

Island County  
Risk Management  
Administration Building  
1 NE 7th Street, Room 211  
Coupeville, WA 98239  
Email: [RiskManagement@islandcountywa.gov](mailto:RiskManagement@islandcountywa.gov)

Business Hours: Monday-Friday, 8:00 a.m. to 4:30 p.m.  
Closed on weekends and official county holidays.

## INSTRUCTIONS FOR COMPLETING A STANDARD TORT CLAIM FORM

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- Prior to completing 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 other available documents or evidence supporting your claim, such as medical records or bills for personal injuries, photographs, proof of ownership for property damages, **repair estimates (a minimum of 2 are required)**, 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:
  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. [ksmith@verizon.net](mailto:ksmith@verizon.net)
  7. 08/09/2008, 8:00 a.m.
  8. If the incident that caused the damages occurred over a period of time, please provide the beginning date/time and the ending date/time.
  9. Washington, Island, No City, On County Road
  10. Patmore Road Eastbound near the intersection with Keystone Road
  11. Island County, Public Works, Roads Division
  12. Smith, Thomas Arthur, 1234 College Way NW, Apt 56, Seattle, WA 98178 (360) 456-3456;  
Tow Truck Driver, Simmons Towing
  13. 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 12 and 13. 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 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 of the person you spoke with.
  17. Please list all of your medical providers including their name, address, contact information, and the type of treatment. If you were treated for a personal injury, please include your medical records and bills.
  18. Attach any other documents that support your claim.
  19. 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 Authorization for Release of Protected Health Information (PHI) form.
- If your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision Form.

# STANDARD TORT CLAIM FORM

## (Island County)

Pursuant to Chapters 4.92 and 4.96 RCW, this form is for filing a tort claim against Island County, its officers, employees or volunteers. Some of the information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure.

For Official Use Only

PLEASE TYPE OR PRINT IN INK

**Submit claim to:** Island County  
Risk Management  
Administration Building  
1 NE 7<sup>th</sup> Street, Room 211  
Coupeville, WA 98239  
Email: RiskManagement@islandcountywa.gov

Business Hours: Mon. – Fri., 8:00 a.m. – 4:30 p.m.  
Closed on weekends and official county holidays.

No.

### CLAIMANT INFORMATION

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 phone number: \_\_\_\_\_  
Home Business
6. Claimant's email address: \_\_\_\_\_

### INCIDENT INFORMATION

7. Date of the incident: \_\_\_\_\_ Time: \_\_\_\_\_ ☐ a.m. ☐ 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: \_\_\_\_\_ ☐ a.m. ☐ p.m. (check one) to \_\_\_\_\_ Time: \_\_\_\_\_ ☐ a.m. ☐ p.m. (check one)  
(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. County 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 County employees, officers, or volunteers having knowledge of this incident:

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**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.

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**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.

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**16.** Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom?

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**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 allegations of this claim.

**19.** I claim damages from Island County 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.

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***Signature of Claimant***

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***Date and place (residential address, city and county)***

Claim# \_\_\_\_\_

**ONLY FOR PERSONAL INJURY CLAIMS**  
**Authorization for Release of Protected Health Information (PHI)**  
**to**  
**Island County Risk Management**

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Name: \_\_\_\_\_  
(Last, First, Middle Initial or Middle Name)

Date of Birth: Month \_\_\_\_ Day \_\_\_\_ Year \_\_\_\_

I hereby authorize disclosure of my protected health information to Island County, Risk Management, for purposes of processing my claim for damages filed with Island County.

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

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I understand the following: **(PLEASE READ AND INITIAL ALL STATEMENTS)**

\_\_\_\_\_  
Initials 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 Island County and not protected for purposes of evaluating and investigating the claim I have filed with Island County.

\_\_\_\_\_  
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 Island County in writing, and that the revocation will be effective as of the date Island County 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 Island County.

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*A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to Island County.*

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:

Island County  
Risk Management  
Administration Building, Room 211  
1 NE 7<sup>th</sup> St  
Coupeville, WA 98277

# 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'S NAME (A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)				DATE OF ACCIDENT (mm/dd/yyyy)		TIME AM PM			
	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									
	YEAR	MAKE	MODEL	LICENSE PLATE NO.	W HERE CAN CAR BE SEEN?		W HEN?			
	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.				
	YEAR	MAKE	MODEL	LICENSE PLATE NO.	STATE AGENCY, IF KNOW N					
	NAME OF OW NER 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.									
	NAME OF OWNER ADDRESS CITY				PHONE					
	DESCRIBE DAMAGE				ESTIMATE \$					
	NAME ADDRESS		PHONE		INJURY		AGEVEH 1VEH 2 VEH 3		PED	OTH
	HOME WORK									
	HOME WORK									
	HOME WORK									
	HOME WORK									
	HOME WORK									
	HOME WORK									
	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.

Straight Road  
Curve – R or L  
Level

Hillcrest  
Uphill  
Downhill

One Lane  
One and One-Half Lane  
Two Lane or Four Lane

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