Standard Tort Claim Form Packet

Carefully read all the information in this packet before completing and presenting your Standard Tort Claim. Please:

- 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; and,
    - Receipts for property value.
- If the requested information cannot be supplied in the space provided, please use additional blank sheets so that your Standard Tort Claim form can be easily read and understood.

Standard Tort Claim Packet includes:

1. Instructions for completing the Standard Tort Claim Form
2. Standard Tort Claim Form
3. Medical Authorization
4. A Vehicle Collision Form only for tort claims involving vehicle accidents/collisions.

Legal requirements for presenting Standard Tort Claims Forms:

- In order to verify the claim and additional supporting information, the law requires that this 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, mail, or email the Standard Tort Claim Form and supporting documents to:

    Rena Sleight
    Risk Management
    Jefferson Healthcare
    834 Sheridan
    Port Townsend, WA 98368
    rsleight@jeffersonhealthcare.org

    Questions please contact Rena Sleight at 360-385-2200 ext. 2010

    Business Hours: 9:00 a.m. – 5:30 p.m. Monday through Friday. Closed on weekends and holidays.

Standard Tort Claim Form

General Liability Claim Form

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against Jefferson County Public Hospital District No.2 dba Jefferson Healthcare, a municipal corporation. Some of the information on this form is required by RCW 4.96.020 and may be subject to public disclosure.

For Official Use only
No.

PLEASE TYPE OR PRINT IN INK

Mail, email or deliver original claim to:
Rena Sleight, Risk Management
Jefferson Healthcare
834 Sheridan
Port Townsend, WA 98368
rsleight@jeffersonhealthcare.org

Business Hours are 9 - 5:30 p.m. Monday through Friday excluding holidays.

CLAIMANT INFORMATION:

1. Claimants 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: _____

INCIDENT INFORMATION:

7. Date of the incident: _____/_____/_____ Time: _____ AM PM
   (mm/dd/yyyy) (circle one)
8. If the incident occurred over a period of time, date of first and last occurrences:
   from ____/____/_____ Time: _____ AM PM to____/____/_____ Time _____ AM PM
   (circle one) (circle one)
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. Names, addresses and telephone numbers of all persons involved in or witness to this incident:
    _____ _____-_____-_____ _____ _____-_____-_____
    Name Number Name Number
    _____ _____-_____-_____ _____ _____-_____-_____
    Name Number Name Number
    _____ _____-_____-_____ _____ _____-_____-_____
    Name Number Name Number

12. Names, addresses and telephone numbers of Hospital employees having knowledge of this incident.

13. Names address and telephone numbers of all individuals not already identified in #11 and #12 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.

14. 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.

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

16. Names, address and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

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

18. I claim damages from Jefferson County Public Hospital District #2 dba Jefferson Healthcare, a municipal corporation, in the sum of $_____.

This Standard Tort 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 the State of Washington on the Claimant's behalf, or by a court-appointed 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
Jefferson Healthcare – Risk Management

Patient name: _____ Telephone #: _____

Date of birth:_____Previous name(s): _____

TO: _____

Please disclose health care information to:

Name (or title) and organization: **Jefferson Healthcare, Risk Management**

Address: 834 Sheridan

City: Port Townsend State: Washington Zip: 98368

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 diagnostic test reports; physician and/or healthcare provider orders; nursing notes; and all other records and references designated by the provider as part of the 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 and treatment records
- Pharmacy prescriptions and reports
- All letters and memos received or sent, including electronic mail, referencing the Patient's 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.
- Financial records related to patient care and treatment

_____

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

MY RIGHTS

____ I understand that my records are protected under HIPAA protected health information 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 Jefferson Healthcare, Risk Management 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 information regarding alcohol, drug or other controlled substance use, counseling referrals and/or a history of testing or treatment or treatment of acquired immune deficiency syndrome.

____ I understand that I may revoke this authorization at any time by notifying Jefferson Healthcare, Risk Management in writing, and that the revocation will be effective as of the date Jefferson Healthcare,

Authorization for Release of Protected Health Information (PHI)
to
Jefferson Healthcare – Risk Management

Risk Management 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 Jefferson Healthcare, Risk Management.

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to Jefferson Healthcare, Risk Management.

_____ _____
Signature of Authorizing Individual Date of Signature

_____
Telephone number

_____
Witness to signature (if patient is over 13 years of age and signing the release):

When the Authorized Individual 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:

Jefferson Healthcare
Risk Management
834 Sheridan
Port Townsend, Washington 98368

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 ☐ 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

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 $

OTHER NON-VEHICLE DAMAGE

WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.

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.

_____

_____

_____

_____

_____

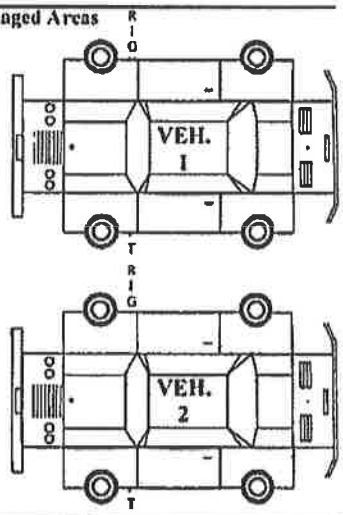
_____

☐ Straight Road
☐ Curve – R or L
☐ Level

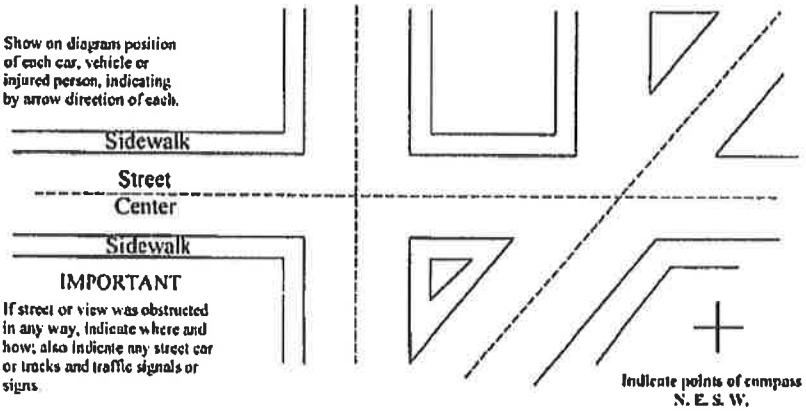
☐ Hillcrest
☐ Uphill
☐ Downhill

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

Mark Damaged Areas



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 trucks and traffic signals or signs.

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

LIGHT CONDITIONS (CHECK ONE)

1 ☐ DAYLIGHT
2 ☐ DAWN
3 ☐ DUSK
4 ☐ DARK STREET LIGHTS ON
5 ☐ DARK STREET LIGHTS OFF
6 ☐ DARK NO STREET LIGHT
7 ☐ OTHER (SPECIFY)

TRAFFIC CONTROL

VEHICLE NO 1	VEHICLE NO 2		
☐	☐	1	SIGNALS
☐	☐	2	STOP SIGN
☐	☐	3	FLASHING RED
☐	☐	4	FLASHING AMBER
☐	☐	5	RR SIGNAL
☐	☐	6	OFFICER/ FLAGMAN
☐	☐	7	YIELD SIGN
☐	☐	8	NO TRAFFIC CONTROL
☐	☐	9	OTHER

TYPE OF ROAD (CHECK ONE OR MORE)

VEHICLE NO 1	VEHICLE NO 2		
☐	☐	1	ONE WAY
☐	☐	2	TWO WAY
☐	☐	3	REVERSIBLE ROAD
☐	☐	4	INTER-CHANGE LOOP RAMP
☐	☐	5	ALLEY
☐	☐	6	TWO WAY-LEFT TURN LANES
☐	☐	1	SEPARATED
☐	☐	2	DIVIDED
☐	☐	3	UNDIVIDED

VEHICLE CONDITION (CHECK ONE OR MORE)

VEHICLE NO 1	VEHICLE NO 2		
☐	☐	1	DEFECTIVE BRAKES
☐	☐	2	DEFECTIVE HEADLIGHTS
☐	☐	3	DEFECTIVE REAR LIGHTS
☐	☐	4	TIRES WORN
☐	☐	5	PUNCTURED OR BLOWN TIRES
☐	☐	6	OTHER (SPECIFY)

ROAD SURFACE (CHECK ONE)

VEHICLE NO 1	VEHICLE NO 2		
☐	☐	1	DRY
☐	☐	2	WET
☐	☐	3	SNOW
☐	☐	4	ICE
☐	☐	5	OTHER (SPECIFY)

WEATHER (CHECK ONE)

1 ☐ CLEAR, CLOUDY & OVERCAST
2 ☐ RAINING
3 ☐ SNOWING
4 ☐ FOG
5 ☐ OTHER (SPECIFY)

NAME OF INVESTIGATING POLICE AGENCY

_____

INVESTIGATING AGENCY REPORT NO

_____

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)***