

Standard Tort Claim Form Packet

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

Presenting a Standard Tort Claim Form

RCW4.96.020 requires citizens to present the Standard Tort Claim form with the government agency named in their claim. The law also requires State and local government agencies to post the Standard Tort Claim form on their websites with instructions on how to complete the form. In compliance with these requirements and for the convenience of citizens, The State Office of Financial Management (OFM) developed a Standard Tort Claim Form Packet, which the Auburn School District has adapted to use.

Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Tort Claim Form
2. Standard Tort Claim Form
3. Medical Authorization
4. Vehicle Collision Form (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's behalf; 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:

Deputy Superintendent of Business and Operations
Auburn School District
915 Fourth Street Northeast
Auburn, Washington 98002

Business Hours: Monday-Friday, 7:00 a.m. to 5:00 p.m.

Closed on weekends, official state holidays, and district holidays.

For further information on the District's days of operation, please consult the District's

Website: <http://www.auburn.wednet.edu>.

INSTRUCTIONS FOR COMPLETING A STANDARD TORT CLAIM FORM

- 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 on how to complete the Standard Tort Claim form:

1. Smith, John Michael
2. 1234 E 21st Avenue, Auburn, WA 98002
3. PO Box 123, Auburn, WA 98071
4. Same (or residence at the time of incident)
5. 253-555-1234
6. johnmsmith@aol.com
7. 8:00 a.m., August 15, 2011
8. If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item
9. Washington, Auburn, Auburn, Terminal Park Elementary, Room 123
10. If applicable: 12th Street @ 21st Avenue
11. Auburn School District
12. Smith, Thomas James, 1234 E 21st Avenue, Auburn, WA 98002
13. List employee names if known or enter "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 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 that 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 for then person with whom you spoke.
17. Please provide all of your medical providers with their names, addresses, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include your medical records and bills.
18. Police reports, witness statements, receipts for medical expenses, property repair, maintenance, etc.
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 Medical Release form.
 - If your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision Form.

Auburn School District No. 408
TORT CLAIM FORM
RCW 4.96.020

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against the Auburn School District ("District"). Information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure. Any person wishing to file a tort claim with the District should fill this form out accurately and completely and present the form in person or by mail to the Deputy Superintendent of the Auburn School District at the address given below between the weekday business hours of 7:00 am and 5:00 pm.

<i>Present to the Deputy Superintendent of Business and Operations at:</i> <i>Auburn School District No. 408 915 Fourth Street Northeast Auburn, Washington 98002</i>	<i>For School District Use Only: Date Received:</i>
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Business Hours: Monday – Friday, 7:00 a.m. – 5:00 p.m.

Closed on weekends and official state and district holidays. For further information regarding the District's dates of operation, please see the District's website: <http://www.auburn.wednet.edu>.

CLAIMANT INFORMATION

1. **Claimant's Name:** _____
2. **Claimant's Date of Birth:** _____
3. **Claimant's Current Residential Address:**

4. **Claimant's Mailing Address (if different):**

5. **Claimant's Residential Address at the Time of the Incident (if different from current address):**

6. **Claimant's Daytime Phone Number:** _____
7. **Claimant's E-Mail Address:** _____

INCIDENT INFORMATION

8. State the amount of damages claimed against the District as a result of the incident.

\$ _____

9. Date of the incident: _____

Time: _____ a.m./p.m. (circle one)

10. Location of incident: _____

11. Names, addresses, and telephone numbers of all persons involved in this incident or who were witnesses to this incident:

(List additional names of witnesses and their contact information, if any, on a separate page and attach to this page.)

12. Names, addresses, and telephone numbers of all District employees having knowledge about this incident:

(List additional names of District employees and their contact information, if any, on a separate page and attach to this page.)

13. Describe the injury or damage which resulted from the incident.

(List additional information, if any, on a separate page and attach to this page.)

14. What is the basis for making this claim against the District? Please provide specific details regarding the conduct and circumstances that you believe the District or its employees engaged in that caused your injury or damage. (Such information can also be provided on separate pages attached to this page.)

Attorney

15. Attorney's contact information if you are represented in this matter by an attorney:

Name: _____

Phone: _____

Email: _____

Address: _____

Signature and Verification

16. 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 of the laws of the State of Washington that the foregoing information is true and correct.

DATED: _____, _____ at _____, *Washington*.

Signature (actual, non-electronic signature required)

Print the Name of the Person Signing

Claim # _____

**Authorization for Release of Protected Health Information (PHI)
To Auburn School District**

Name: _____
(Last, First, Middle Initial or Middle Name)

Date of Birth: Month _____ Day _____ Year _____

I hereby authorize disclosure of my protected health information to Deputy Superintendant, Auburn School District for purposes of processing my claim for damages filed with the Auburn 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 Auburn School District and not protected for purposes of evaluating and investigating the claim I have filed with the Auburn 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 Auburn School District, Deputy Superintendent, in writing, and that the revocation will be effective as of the date the Deputy Superintendent 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 Auburn School District, Deputy Superintendent.

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to Auburn School District, Deputy Superintendent.

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:

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

To the Provider or Records Custodian:

Please send legible copies of all records to:
Deputy Superintendent of Business and Operations
Auburn School District
915 Fourth Street Northeast
Auburn, Washington 98002

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 <input type="checkbox"/> PM <input type="checkbox"/>			
	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				
INJURED PARTIES	DESCRIBE DAMAGE						ESTIMATE \$			
	NAME	ADDRESS	PHONE	INJURY	AGE	VEH 1	VEH 2	VEH 3	PED	OTH
WITNESSES				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 tracks and traffic signals or signs.

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

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

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)