

# 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**

Engrossed Substitute House Bill 1553, effective July 26, 2009, 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.

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

1. Instructions for completing the Standard Tort Claim Form (SF-210)
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; 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:**

Central Valley School District  
Business Services Department  
19307 E. Cataldo  
Spokane Valley, WA 99016

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

## 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 on how to complete the Standard Tort Claim Form (#SF
  1. Smith, Karen Michelle
  2. 11234 E. 19<sup>th</sup> Ave, Spokane Valley, WA 99206
  3. PO Box 910, Spokane Valley, WA 99214
  4. Same (or residence at the time of incident)
  5. 509-123-4567
  6. [KarenS@aol.com](mailto:KarenS@aol.com)
  7. 8:00 a.m., August 9, 2009
  8. If the incident that caused the damages occurred over a period of time, please provide beginning time and the ending time in item 7
  9. Washington, Spokane, Spokane Valley, Central Valley High School, Rm 123
  10. If applicable: Sullivan Southbound, at 8<sup>th</sup> Ave intersection
  11. Central Valley School District
  12. Smith, Thomas Arthur, 4234 S. Sullivan, Spokane Valley, WA 99037 (509) 926-3456;
  13. List employee names if known or enter "Unknown"
  14. List all other witnesses having knowledge of the incident in question, with their 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.
  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 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.
  18. Police reports, witness statements, receipts for medical expenses, property repair or replacement, 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.

# 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 State of Washington. 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 RCW, Standard Tort Claims cannot be submitted electronically.

## PLEASE TYPE OR PRINT IN INK

### Mail or deliver original claim to:

Central Valley School District  
Department of Business Services  
19307 E. Cataldo  
Spokane Valley, WA 99016

Business Hours: Mon. - Fri. 8:00 a.m. - 4:30 p.m.  
Closed on weekends and official state holidays.

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## 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 telephone number:

\_\_\_\_\_ *Home*                      \_\_\_\_\_ *Business*

6. Claimant's e-mail 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.    to \_\_\_\_\_, Time: \_\_\_\_\_ a.m.    p.m.  
*(mm/dd/yyyy)*                      *(mm/dd/yyyy)*

9. Location of incident:

\_\_\_\_\_ *State, County and City, if applicable Place where occurred*

10. If the incident occurred on a street or highway:

\_\_\_\_\_ *Name of street or highway, Milepost number, intersection or nearest intersecting street*

11. State/local 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:

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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 claim's allegations.

**19.** I claim damages from the State of Washington 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  
Central Valley School District, Department of Business Services**

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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 Central Valley School District, Department of Business Services, for purposes of processing my claim for damages filed with the State of Washington.**

**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:**

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**Financial records related to my care and treatment**

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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).

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I understand that my health information may be subject to re-disclosure by Central Valley School District, Department of Business Services and not protected for purposes of evaluating and investigating the claim I have filed with the State of Washington.

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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.

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I understand that I may revoke this authorization at any time by notifying Central Valley School District, Department of Business Services in writing, and that the revocation will be effective as of the date OFM 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.

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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 Central Valley School District, Department of Business Services.

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*A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to Central Valley School District, Department of Business Services.*

Signature of Authorizing Individual:

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Date of Signature: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Witness (where patient is over 13 and signing the release):

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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

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### **To the Provider or Records Custodian:**

Please send legible copies of all records to:

Central Valley School District  
Department of Business Services  
19307 E. Cataldo  
Spokane Valley, WA 99016

# 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.				
	YEAR	MAKE	MODEL	LICENSE PLATE NO.	STATE AGENCY, IF KNOWN					
OTHER VEHICLE INFORMATION (VEHICLE #2)	NAME OF OWNER		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.									
OTHER NON-VEHICLE DAMAGE	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.

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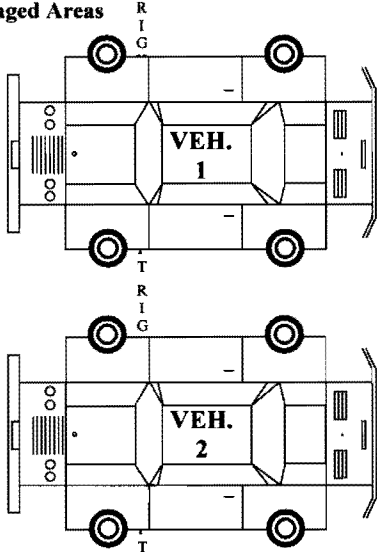
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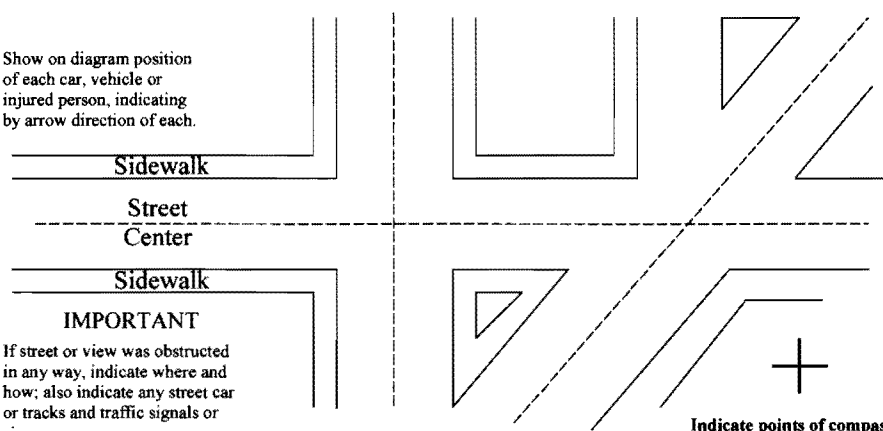
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<input type="checkbox"/> Straight Road <input type="checkbox"/> Curve – R or L <input type="checkbox"/> Level	<input type="checkbox"/> Hillcrest <input type="checkbox"/> Uphill <input type="checkbox"/> Downhill	<input type="checkbox"/> One Lane <input type="checkbox"/> One and One-Half Lane <input type="checkbox"/> Two Lane or Four Lane	<b>Mark Damaged Areas</b> 
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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 1 <input type="checkbox"/> SIGNALS	VEHICLE NO. 1 NO. 2 1 <input type="checkbox"/> ONE WAY	VEHICLE NO. 1 NO. 2 1 <input type="checkbox"/> DEFECTIVE BRAKES	VEHICLE NO. 1 NO. 2 1 <input type="checkbox"/> DRY	1 <input type="checkbox"/> CLEAR, CLOUDY & OVERCAST
2 <input type="checkbox"/> DAWN	2 <input type="checkbox"/> STOP SIGN	2 <input type="checkbox"/> TWO WAY	2 <input type="checkbox"/> DEFECTIVE HEADLIGHTS	2 <input type="checkbox"/> WET	2 <input type="checkbox"/> RAINING
3 <input type="checkbox"/> DUSK	3 <input type="checkbox"/> FLASHING RED	3 <input type="checkbox"/> REVERSIBLE ROAD	3 <input type="checkbox"/> DEFECTIVE REAR LIGHTS	3 <input type="checkbox"/> SNOW	3 <input type="checkbox"/> SNOWING
4 <input type="checkbox"/> DARK STREET LIGHTS ON	4 <input type="checkbox"/> FLASHING AMBER	4 <input type="checkbox"/> INTER-CHANGE LOOP RAMP	4 <input type="checkbox"/> TIRES WORN	4 <input type="checkbox"/> ICE	4 <input type="checkbox"/> FOG
5 <input type="checkbox"/> DARK STREET LIGHTS OFF	5 <input type="checkbox"/> RR SIGNAL	5 <input type="checkbox"/> ALLEY	5 <input type="checkbox"/> PUNCTURED OR BLOWN TIRES	5 <input type="checkbox"/> OTHER (SPECIFY)	5 <input type="checkbox"/> OTHER (SPECIFY)
6 <input type="checkbox"/> DARK NO STREET LIGHT	6 <input type="checkbox"/> OFFICER/FLAGMAN	6 <input type="checkbox"/> TWO WAY-LEFT TURN LANES	6 <input type="checkbox"/> OTHER (SPECIFY)	NAME OF INVESTIGATING POLICE AGENCY: _____  INVESTIGATING AGENCY REPORT NO. _____	
7 <input type="checkbox"/> OTHER (SPECIFY)	7 <input type="checkbox"/> YIELD SIGN	1 <input type="checkbox"/> SEPARATED			
	8 <input type="checkbox"/> NO TRAFFIC CONTROL	2 <input type="checkbox"/> DIVIDED			
	9 <input type="checkbox"/> OTHER	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)*