

WHATCOM COUNTY

Tort Claim Packet

CLAIM FORMS AND INSTRUCTIONS

Please carefully read all of the information in this packet before completing and submitting your claim for damages.

The following forms in this packet are for filing a tort claim against Whatcom County, pursuant to RCW 4.96. All claim forms must be signed and delivered to the Whatcom County Council's Office.

Documents contained in this packet:

1. Claim for Damages
2. Vehicle Collision Form (required if vehicle is involved)
3. Medical Authorization (required if you are claiming personal injuries)

Type or print clearly in ink and sign the Claim for Damages form. If the requested information cannot be written in the space provided, please use additional blank sheets so your claim can be easily read and understood. Do not write on the back of the forms.

The more information you provide, the more accurate we can be in our response. Please remember the investigation process may take some time. You are required to mitigate (minimize) your own losses. You may wish to look to your own insurer first if time is of the essence.

For a tort claim notice to be effective, the packet must be substantially completed and delivered or mailed to:

WHATCOM COUNTY
Clerk of the County Council
311 Grand Ave., Ste. 105
Bellingham, WA 98225-4079

Business Hours: Monday- Friday 8:30 a.m. to 4:30 p.m.
Closed on weekends and holidays
Office Telephone Number: 360-778-5010

We will not accept service of your claim by E-mail or Fax. Please feel free to contact our Civil Division in the Prosecuting Attorney's office at (360) 778-5755 with any questions regarding this packet or the claims process.

After receiving your claim, additional information may be requested. This information may include documents or other evidence supporting your claim such as medical records or bills for personal injuries, photographs, proof of ownership for property damages, estimates for damages, receipts for property value, or other relevant documents or evidence. Please respond promptly if such additional documentation is requested.

WC CLAIM NO.

CLAIM FOR DAMAGES

Review Instructions Prior to Completing this Form
PLEASE TYPE OR PRINT IN INK

Pursuant to RCW 4.96, this form is for filing a tort claim against Whatcom County. The requested information on this form may be subject to public disclosure pursuant to the Public Records Act (RCW 42.56) or other law.

All Claim forms must be signed and the original provided to the Whatcom County Council's Office. Forms must be presented in person or mailed to:

WHATCOM COUNTY
Clerk of the County Council
311 Grand Ave., Ste. 105
Bellingham, WA 98225-4079

Business Hours: Monday- Friday 8:30 a.m. to 4:30 p.m.
Closed on weekends and holidays
Office Telephone Number: 360-778-5010

Name of Claimant: _____
Last Name First Middle Date of Birth

Residential Address: _____
Street City State Zip

Mailing Address (if different) _____
Street City State Zip

Phone Number: () _____ Email: _____

Date of Incident: _____ Time of Incident: _____ am pm

Location of incident: _____
Address City, Building or Office if applicable

Location if the incident occurred on a Street or Highway: _____

***Please attach any law enforcement reports generated in connection with the accident, if any**

Name of Street or Highway, Milepost Number OR At the intersection with/or nearest cross street

County agency or department involved: _____

Names, Addresses and Telephone Numbers of all county employees having knowledge about this incident: _____

Names, Addresses and Telephone Numbers of all persons involved in or witnesses to this incident and a description of the nature of their knowledge or involvement: _____

Name of Insurance Company and Contact Information (if applicable): _____

Claim # _____ Claim Representative _____

I am claiming damages from Whatcom 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 or an attorney admitted to practice in Washington State on 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

City and County

Signature of Representative /relationship to Claimant

Date

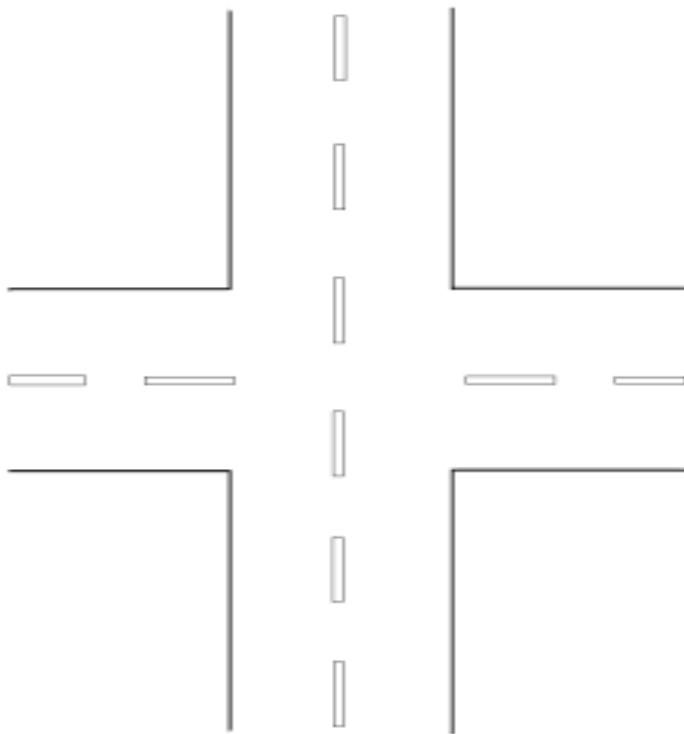
City and County

Identity of Signature above and/or relationship to Claimant: _____

Address:		Address:	
Contact Phone:		Contact Phone:	

Sketch The Accident Scene:

Please use diagram below or use blank space to sketch the accident.



Medical Authorization for Release of Protected Health Information to Whatcom County

Full Legal Name: _____ DOB: _____

Previous Names used: _____

I hereby authorize disclosure of my protected health information to Whatcom County for purposes of processing my claim. I understand that by signing this document, I authorize the release of the following information:

Entire Medical Record for all services, including patient history and physical exam, medical and office notes, laboratory reports, test results, x-rays, films, referrals, consults, billing records, insurance records, and all other records or references designated by the provider as part of its medical record. All letters and memos received or sent, including electronic mail, referencing my treatment, urgent care, outpatient or other clinic visit information, and financial records related to my care and treatment.

Other:

The individual signing this form agrees and acknowledges:

(i) **Voluntary Authorization:** I understand that my records are protected under HIPAA/PHI regulations and the Washington State Care Information Act (RCW 70.02). This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall expire one year from today's date.

(iii) **Right to Revoke:** I understand I have the right to revoke this authorization at any time by writing to the County Council's Office and informing them to revoke my authorization.

(iv) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that my health information may be subject to re-disclosure by the County and not protected for purposes of evaluating and investigating the claim I have filed with Whatcom County.

SIGNATURE:

Patient/Legal _____ Date: _____

Telephone No. _____

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 _____