Standard Tort Claim Form Packet

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

Washington Law that Impacts Presenting a Standard Tort Claim Form

Chapter 4.96 RCW requires citizens to present the Standard Tort Claim form with the government entity named in their claim. The law requires local government entities to provide the Standard Tort Claim form with instructions on how to complete the form. In compliance with these requirements and for the convenience of citizens, Jefferson County Fire Protection District No. 2, dba Quilcene Fire Rescue, has made available a Standard Tort Claim Form Packet. The Standard Tort Claim form may be submitted directly to Quilcene Fire Rescue.

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 (for tort claims involving injury)
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

Deliver in Person or Mail the Standard Tort Claim Form and Supporting Documents to:

Via Personal Delivery:

Robert Rewitzer
District Secretary
Quilcene Fire Rescue
61 Herbert Street
Quilcene, WA 98376

Via Mail:

Robert Rewitzer
District Secretary
Quilcene Fire Rescue
P.O. Box 433
Quilcene, WA 98376

Office hours are Monday-Thursday, 8:00 a.m. to 3:30 p.m.
Office is closed on weekends and official state holidays
Office may be closed during fire/EMS calls
Telephone 360-765-3333 to verify availability

INTRUCTIONS FOR COMPLETING A STANDARD TORT CLAIM FORM

- Before presenting a Standard Tort Claim form, 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, 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. Doe, John Walter 02/14/1969
2. 1234 Alpha St., Apt. 01, Delta City, WA, 98765
3. PO Box 123, Delta City, WA, 98765
4. Same (or residence at the time of incident)
5. 360-123-4567
6. John.Doe@aol.com
7. 05/09/2021 8:00 a.m.
8. If the incident that caused the damages occurred over a period of time, provide the beginning date and time and the ending date and time.
9. Parking lot of 567 Bravo Road, Quilcene, Jefferson, WA
10. (If applicable) US Highway 101, Milepost 294, near Center Road
11. (If known, or enter "Unknown") Medic Tim Peterson, Aid Unit 21
12. (If known, or enter "Unknown") Lt. Smith, Firefighter Jones
13. Thomas Arthur Johnson, 1234 Echo Way, Apt. 56, Kilo, WA 98765 (360) 867-5309
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, include her name, address, telephone number, and indicate she witnessed the incident.
15. Describe in detail the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when, and why.
16. Reported on 05/09/2021 to Jefferson County Sheriff's Deputy Huckleberry. If you reported this incident to law enforcement, provide a copy of the report or contact information of the law enforcement agency you spoke with.
17. Provide contact information for all your medical providers, including their names, address, telephone numbers, as well as a description of the treatment provided. If you were treated for a personal injury, include your medical records and bills.
18. 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, sign and attach the Authorization for Release of Protected Health Information form for each medical provider.
- If your claim involves a motor vehicle accident, complete, sign, and attach the Vehicle Collision Form.

STANDARD TORT CLAIM FORM

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against Jefferson County Fire Protection District No. 2, dba Quilcene Fire Rescue. Some of the information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure. Pursuant to the law, Standard Tort Claim forms cannot be submitted electronically (via e-mail or fax).

TYPE OR PRINT IN INK

Mail to:
Robert Rewitzer
District Secretary
Quilcene Fire Rescue
PO Box 433
Quilcene, WA 98376

OR

Deliver to:
Robert Rewitzer
District Secretary
Quilcene Fire Rescue
61 Herbert Street
Quilcene, WA 98376

For Official Use Only
No.

Business Hours: Monday to Thursday, 8:00 a.m. - 3:30 p.m., excluding holidays.

CLAIMANT INFORMATION

1. Claimant's name:

_____
Last name First name Middle name Date of birth (mm/dd/yyyy)

2. Claimant's current residential address:

_____

3. Mailing address (if different from above):

_____

4. Claimants address at the time of the incident (if different from current residential address):

_____

5. Claimant's telephone number: _____ Home _____ Cell _____ Work

6. Claimant's email address: _____

INCIDENT INFORMATION

7. Date/Time of incident: _____ mm/dd/yyyy _____ Time ☐ a.m. ☐ p.m. Check one

8. If the incident occurred over a period of time, date of first and last occurrences:

from _____ mm/dd/yyyy _____ Time ☐ a.m. ☐ p.m. to _____ mm/dd/yyyy _____ Time ☐ a.m. ☐ p.m.

9. Location of incident: _____
Specific location, address, city, county, state where occurred

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

_____
Name of street or highway, mile post number, intersection with or nearest intersecting street

11. District response unit or members allegedly responsible for damage/injury:

_____

12. Names of any other District members having direct knowledge of this incident:

_____

13. Names, addresses, and telephone numbers of all witnesses or other persons involved in this incident:

_____

_____

_____

14. Names, addresses, and telephone numbers of all individuals not already identified in #12 and #13 above who have knowledge regarding the liability issues involved in this incident or knowledge of the Claimant's resulting damages. Include a brief description as to the nature and extent of each person's knowledge. Attach additional sheets if necessary.

15. Describe the cause of the injury or damage(s). Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.

16. Has the incident been reported to law enforcement, safety, or security personnel? If so, when and to whom? Attach a copy of the report or contact information.

17. Names, addresses, and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

18. I claim damages from Quilcene Fire Rescue in the sum of $ _____

19. Attach documents which support the claim's allocations.

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 (address, city, county, state)
Signature of Representative	Date and place (address, city, county, state)
Printed Name of Representative	Bar number (if applicable)

Claimant to complete an authorization for EACH medical provider listed in claim

Claim # _____

Authorization for Release of Protected Health Information (PHI) to Quilcene Fire Rescue

Medical Provider: _____
Name of provider, practice, clinic, hospital, urgent care, or treatment center

Address of Medical Provider: _____
Complete mailing address

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

I hereby authorize disclosure of my protected health information to Quilcene Fire Rescue, for purposes of processing my claim for damages filed with Quilcene Fire Rescue.

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.
- Urgent care, outpatient, or other clinic visit information, pharmacy prescriptions, records, and reports.
- All letters and memos received or sent, including electronic mail, referencing my treatment.
- Financial records related to my care and treatment.
- Chemical dependency assessment, testing, referral, or treatment records.
- Psychiatric, mental, and behavioral health records, including treatment notes, assessments, testing documents and results, and medical records related to mental health diagnosis and treatment.
- Information related to alleged sexual assault or sexually transmitted disease, including test results.
- HIV/AIDS test results and medical information related to HIV/AIDS testing or treatment.

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

_____ I understand that my records are protected under HIPAA/PHI regulations and the Washington State Health Care Information Act (Chapter 70.02 RCW).

_____ I understand that my health information may be subject to re-disclosure by Quilcene Fire Rescue for purposes of evaluating and investigating the claim I have filed with Quilcene Fire Rescue.

_____ I understand that the specific information to be disclosed in my medical record may include information regarding chemical dependency and treatment, mental health, sexually transmitted diseases, and HIV/AIDS test results, diagnosis, or treatment.

_____ I understand that I may revoke this authorization at any time by notifying Quilcene Fire Rescue in writing, and that the revocation will be effective as of the date Quilcene Fire Rescue receives it. Any records obtained pursuant to this Authorization 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.

A photocopy or fax of this Authorization carries the same authority as the original for purposes of releasing my records.

_____ _____ _____
Signature of Authorizing Individual Date Telephone number

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

_____
Printed Name of Parent, Guardian, or Personal Representative

TO THE PROVIDER OR RECORDS CUSTODIAN:
Send legible copies of all records to:

Quilcene Fire Rescue
Attention: District Secretary
PO Box 433
Quilcene, WA 98376

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 (VEHICI F #2)

YEAR | MAKE | MODEL | LICENS E 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

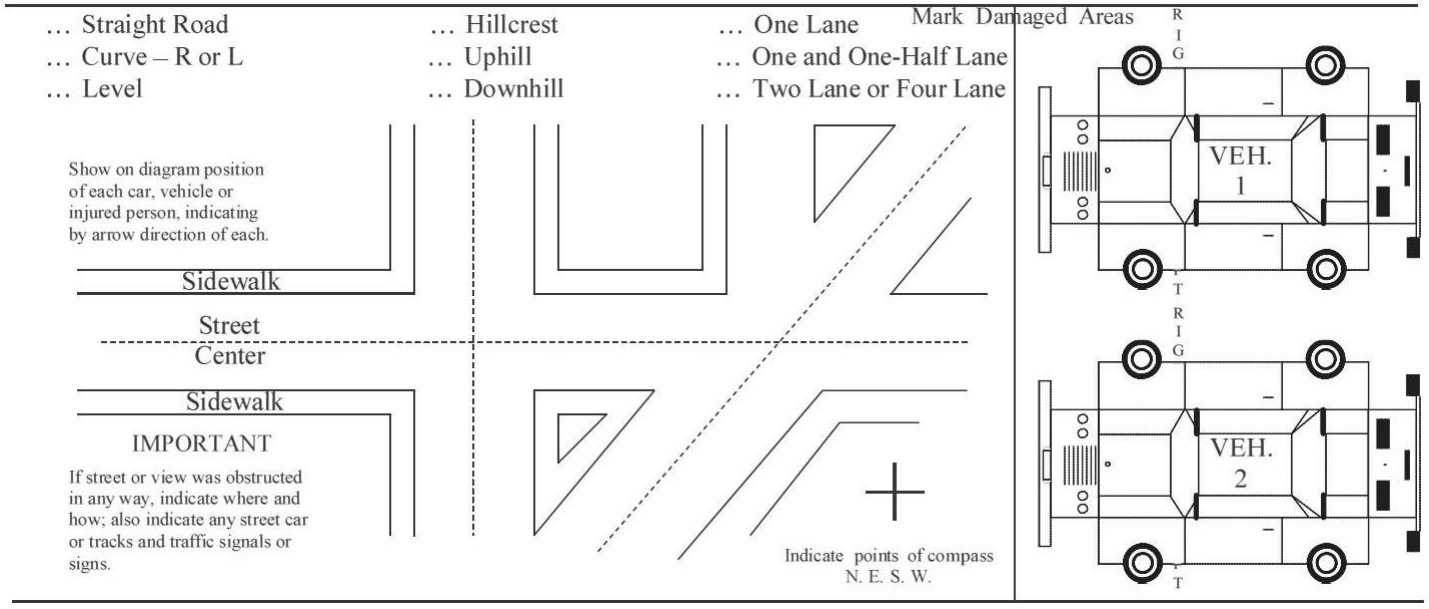
HOME WORK

HOME WORK

(June 2015)

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.



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	
4 ☐ DARK STREET LIGHTS ON	☐ 3 ☐ FLASHING RED	☐ 3 ☐ REVERSIBLE ROAD	☐ 3 ☐ DEFECTIVE REAR LIGHTS	☐ 3 ☐ SNOW	3 ☐ SNOWING
5 ☐ DARK STREET LIGHTS OFF	☐ 4 ☐ FLASHING AMBER	☐ 4 ☐ INTER-CHANGE LOOP RAMP	☐ 4 ☐ TIRES WORN	☐ 4 ☐ ICE	4 ☐ FOG
6 ☐ DARK NO STREET LIGHT	☐ 5 ☐ RR SIGNAL	☐ 5 ☐ ALLEY	☐ 5 ☐ PUNCTURED OR BLOWN TIRES	☐ 5 ☐ OTHER (SPECIFY)	5 ☐ OTHER (SPECIFY)
7 ☐ OTHER (SPECIFY)	☐ 6 ☐ OFFICER/ FLAGMAN	☐ 6 ☐ TWO WAY-LEFT TURN LANES	☐ 6 ☐ OTHER (SPECIFY)		
	☐ 7 ☐ YIELD SIGN	☐ 1 ☐ SEPARATED			
	☐ 8 ☐ NO TRAFFIC CONTROL	☐ 2 ☐ DIVIDED			
	☐ 9 ☐ OTHER	☐ 3 ☐ UNDIVIDED			

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)