

City of SeaTac Tort Claim Packet

Please *carefully read all of the information in this packet* before completing and presenting your Tort Claim. Tort claims are subject to public disclosure pursuant to RCW 42.56.

NOTE: all documents received by the City of SeaTac become the property of the City and **will not be returned**. Please keep a copy for your records and do not send original attachments if you may want them returned.

Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Tort Claim Form
2. Standard Tort Claim Form (SF 210)
3. Medical Authorization (only for tort claims involving bodily injury)
4. Vehicle Collision Form (only for tort claims involving vehicle accidents/collisions)
5. Mandatory Medicare Beneficiary Reporting Form

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, Mail, or Email the Washington State Tort Claim Form & Supporting Documents to:

City Clerk's Office
City of SeaTac
4800 South 188th Street
SeaTac, Washington 98188
Phone (206) 973-4633
Email: cityclerk@seatacwa.gov

Business Hours: Monday-Friday, 8:30 a.m. to 5:00 p.m. Closed on weekends and official state holidays.

INSTRUCTIONS FOR COMPLETING TORT CLAIM FORM

General Liability Claim Form #SF 210

- ✓ Before filing a Tort Claim, please read these instructions, the Tort Claim form and other appropriate forms in their entirety.
- ✓ Type or print **clearly** in ink and sign the Tort Claim form. **Do not staple or tape documents**. Do not put in claim form in binders or add divider tabs as all documents must be scanned.
- ✓ 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 claim can be easily read and understood.

- ✓ The following are *examples* on how to complete the Tort Claim Form #SF 210:
 - 1) Smith, John – 02/20/1965
 - 2) #987654 (for use by Department of Corrections inmates only)
 - 3) 1234 Anywhere Drive, SeaTac WA 98188
 - 4) PO Box 123, SeaTac WA 98188
 - 5) Same (or residence at the time of incident)
 - 6) (206) 123-4567 – (206) 987-6543
 - 7) JSmith@gmail.com
 - 8) 8/9/2018 8:00 a.m.,
 - 9) If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item 8.
 - 10) Parking lot of Angle Lake Park in SeaTac

 - 11) South 188th Street and International Boulevard, closest to the southeast corner of the intersection
 - 12) City of SeaTac, Public Works Department
 - 13) Doe, Thomas, 1234 College Way, Seattle WA 98178, (360) 456-3456; Tow Truck Driver, Acme Towing
 - 14) Unknown
 - 15) List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items 13 and 14. 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.
 - 16) **Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.**
 - 17) 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.
 - 18) 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.
 - 19) Please attach any additional documents that support your claim.
 - 20) 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 filing a personal injury claim, please sign and attach the Medical Release.
- ✓ If your claim involves a motor vehicle accident, please complete, sign, and attach the vehicle accident form.

STANDARD TORT CLAIM FORM

General Liability Claim Form #SF 210

For Official Use Only

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against the City of SeaTac. Some of the information requested on this form is required by RCW 4.92.100 and is subject to public disclosure pursuant to RCW 42.56.

PLEASE TYPE OR PRINT CLEARLY IN INK

Mail or deliver City Clerk's Office
original claim to: City of SeaTac
4800 South 188th Street
SeaTac, Washington 98188
Phone: (206) 973-4633
Email: cityclerk@seatacwa.gov

Business Hours: Monday – Friday 8:30 a.m. – 5:00 p.m.
Closed on weekends and official state holidays.

- 1. Claimant's name: _____
Last name First Middle Date of birth (mm/dd/yyyy)
- 2. Inmate DOC number (if applicable): _____
- 3. Current residential address: _____
- 4. Mailing address (if different): _____
- 5. Residential address at the time of the incident: _____
(if different from current address)
- 6. Claimant's daytime telephone number: _____
Home Business or Cell
- 7. Claimant's e-mail address: _____
- 8. Date of the incident: _____ Time: _____ a.m. p.m. (check one)
(mm/dd/yyyy)
- 9. If the incident occurred over a period of time, date of first and last occurrences:
from _____ Time: _____ a.m. p.m.
(mm/dd/yyyy) (mm/dd/yyyy)
to _____ Time: _____ a.m. p.m.
(mm/dd/yyyy) (mm/dd/yyyy)
- 10. Location of incident: _____

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

Name of street or highway	Milepost number	At the intersection with or nearest intersecting street
---------------------------	-----------------	---

12. City department you believe is responsible for damage/injury:

13. Names and telephone numbers of all persons involved in or witness to this incident:

14. Names and telephone numbers of all City employees having knowledge about this incident:

15. Names and telephone numbers of all individuals not already identified in #13 and #14 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.

16. Describe how the City of SeaTac caused your injuries or damages (**if your injuries or damages were not caused by the City, do not use this form. You must file your claim against the correct entity**). Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.

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

18. Names, addresses and telephone numbers of treating medical providers. Submit copies of all medical reports and billings.

19. Please attach documents which support the allegations of the claim.

20. I claim damages from the City of SeaTac in the sum of \$_____.

This Claim form must be signed by one of the following (check appropriate box).

- Claimant
- Person holding a written power of attorney from the Claimant
- Attorney in fact for the Claimant
- Attorney admitted to practice in Washington State on the Claimant's behalf
- 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)

Or

Signature of Representative

Date and place (residential address, city and county)

Print Name of Representative

Bar Number (if applicable)

**Authorization for Release of Protected Health Information (PHI)
to
Risk Management Department, City of SeaTac**

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

Date of Birth: Month ____ Day ____ Year _____

I hereby authorize disclosure of my protected health information to the Risk Management Department of the City of SeaTac for purposes of processing my claim for damages filed with the City of SeaTac.

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, compliance with treatment and any other subject related to my medical 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
Initials Washington State Health Care Information Act (RCW 70.02).

_____ I understand that my health information may be subject to re-disclosure by Risk Management and
Initials not protected for purposes of evaluating and investigating the claim I have filed with the City of
SeaTac.

_____ I understand that the specific information to be disclosed in my medical record may include
Initials 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 Risk Management in
Initials writing, and that the revocation will be effective as of the date 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 the City of SeaTac.

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

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:

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:

Risk Management Department
Confidential Contents
City of SeaTac
4800 South 188th Street
SeaTac, Washington 98188

VEHICLE COLLISION FORM

PLEASE TYPE OR PRINT IN INK

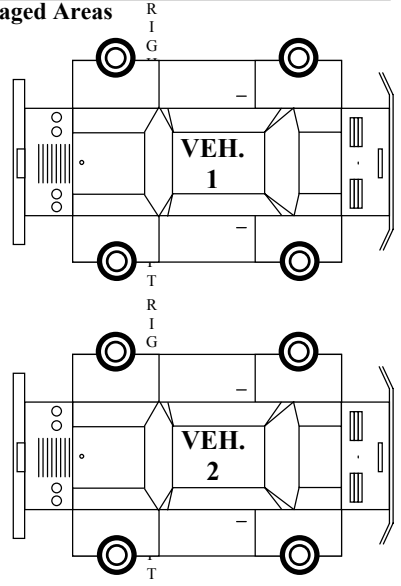
Please attach this form to your standard tort claim form, if the claim involves a vehicle collision.

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	HOME PHONE WORK PHONE				
	(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.	CITY DEPT. 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				

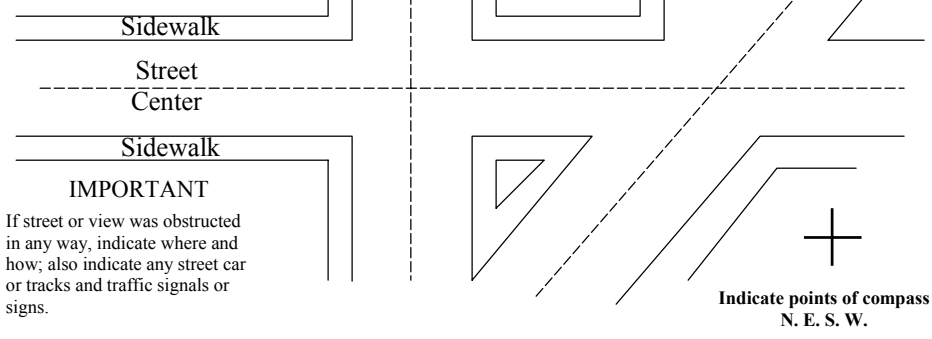
COMPLETE ALL DETAILS

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.

- | | | |
|---|------------------------------------|--|
| <input type="checkbox"/> Straight Road | <input type="checkbox"/> Hillcrest | <input type="checkbox"/> One Lane |
| <input type="checkbox"/> Curve – R or L | <input type="checkbox"/> Uphill | <input type="checkbox"/> One and One-Half Lane |
| <input type="checkbox"/> Level | <input type="checkbox"/> Downhill | <input type="checkbox"/> Two Lane or Four Lane |



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.

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	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	1 <input type="checkbox"/> CLEAR, CLOUDY & OVERCAST
2 <input type="checkbox"/> DAWN	<input type="checkbox"/> 1 <input type="checkbox"/> SIGNALS	<input type="checkbox"/> 1 <input type="checkbox"/> ONE WAY	<input type="checkbox"/> 1 <input type="checkbox"/> DEFECTIVE BRAKES	<input type="checkbox"/> 1 <input type="checkbox"/> DRY	2 <input type="checkbox"/> RAINING
3 <input type="checkbox"/> DUSK	<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	3 <input type="checkbox"/> SNOWING
4 <input type="checkbox"/> DARK STREET LIGHTS ON	<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	4 <input type="checkbox"/> FOG
5 <input type="checkbox"/> DARK STREET LIGHTS OFF	<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	5 <input type="checkbox"/> OTHER (SPECIFY)
6 <input type="checkbox"/> DARK NO STREET LIGHT	<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)	
7 <input type="checkbox"/> OTHER (SPECIFY)	<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)		
	<input type="checkbox"/> 7 <input type="checkbox"/> YIELD SIGN	<input type="checkbox"/> 1 <input type="checkbox"/> SEPARATED		NAME OF INVESTIGATING POLICE AGENCY:	
	<input type="checkbox"/> 8 <input type="checkbox"/> NO TRAFFIC CONTROL	<input type="checkbox"/> 2 <input type="checkbox"/> DIVIDED		INVESTIGATING AGENCY REPORT NO.	
	<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)