INSTRUCTIONS FOR COMPLETING A 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.

- 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, Karen Michelle
2. 1234 College Way NW, Apt. 56, Seattle WA 98178
3. PO Box 910, Seattle WA 98178
4. Same (or residence at the time of incident)
5. (206) 123-4567
6. 8:00 a.m., August 9, 2004
7. If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item 7.
8. Washington, Thurston, Tumwater, Campus of South Puget Sound Community College, Building number 22.
9. I-5, Southbound, Milepost 109, near the Martin Way Exit
10. Washington State Department of Transportation, Highway
11. Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Seattle WA 98178 (360) 456-3456; Tow Truck Driver, Nisqually Towing
12. Unknown
13. 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 she witnessed the incident.
14. 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.
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 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
No.

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against the State of Washington. Information requested on this form is required by RCW 4.92.100 and may be subject to public disclosure. Claims involving accidents with vehicles operated by state employees should be filed on a Standard Vehicle Accident Claim Form (#SF 138), not this form. Claim forms cannot be submitted electronically (via e-mail or fax).

PLEASE TYPE OR PRINT IN INK

Mail or deliver original claim to:

Office of Financial Management
Risk Management Division
300 General Administration Building
Post Office Box 41027, MS: 41027
Olympia, Washington 98504-1027
Business Hours: Mon. - Fri. 8:00 a.m. - 5:00 p.m.
Closed on offical state holidays

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 for on/at the date 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. *(check one)* to _____, Time: ____☐a.m. ☐p.m. *(check one)*
(mm/dd/yyyy) *(mm/dd/yyyy)*

9. Location of incident: _____
State and county *City, if applicable* *Place where occurred*

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

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

11. State 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:

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.

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.

16. Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom?

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

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)***

Claim# _____

Authorization for Release of Protected Health Information (PHI) to The Office of Financial Management (OFM) Risk Management Division

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 Office of Financial Management, Risk Management Division, 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: _____.

Financial records related to my care and treatment

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

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

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

_____ Initials 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.

_____ Initials I understand that I may revoke this authorization at any time by notifying OFM 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.

_____ Initials 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 OFM.

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

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:

The Office of Financial Management
Risk Management Division
Attn: Claims Unit
P.O. Box 41027
Olympia, WA 98504-1027

STANDARD VEHICLE ACCIDENT TORT CLAIM FORM

PLEASE TYPE OR PRINT IN INK

Pursuant to RCW 4.92, this form is provided for your convenience when filing a tort claim against the State of Washington involving an accident with a vehicle being operated by a state employee.

Mail or deliver original claim in duplicate to:

Office of Financial Management
Risk Management Division
300 General Administration Building
Post Office Box 41027, MS: 41027
Olympia, Washington 98504-1027

For Official Use Only

This Claim Form cannot be submitted electronically (via e-mail or fax)

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 (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

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.

_____

_____

_____

_____

_____

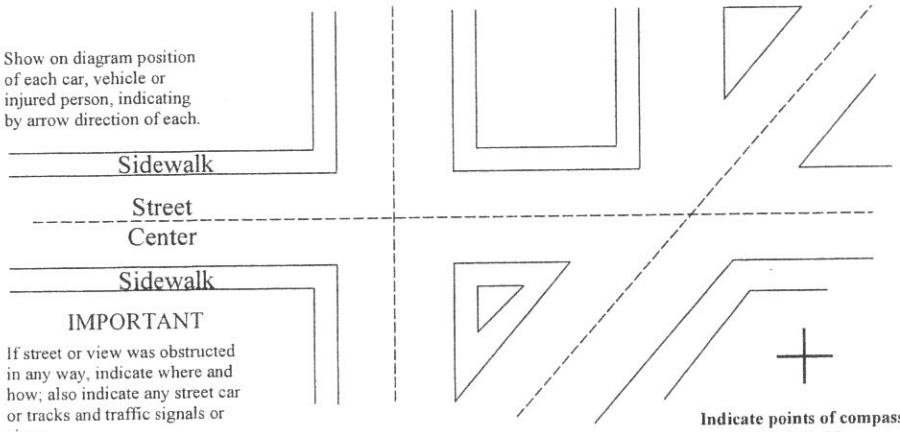
_____

☐ Straight Road
☐ Curve – R or L
☐ Level

☐ Hillcrest
☐ Uphill
☐ Downhill

☐ One Lane
☐ One and One-Half Lane
☐ Two Lane or Four Lane

Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.

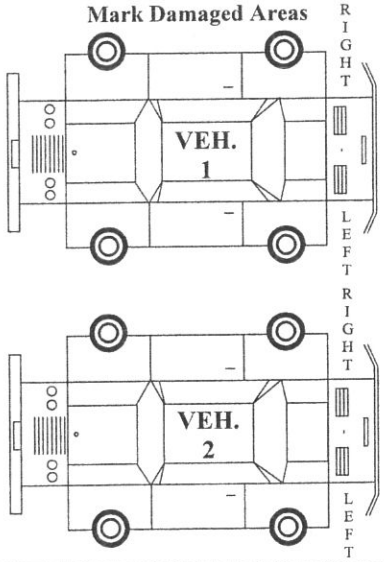


IMPORTANT

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.

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

Mark Damaged Areas



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	3 ☐ SNOWING
4 ☐ DARK STREET LIGHTS ON	☐ 3 ☐ FLASHING RED	☐ 3 ☐ REVERSIBLE ROAD	☐ 3 ☐ DEFECTIVE REAR LIGHTS	☐ 3 ☐ SNOW	4 ☐ FOG
5 ☐ DARK STREET LIGHTS OFF	☐ 4 ☐ FLASHING AMBER	☐ 4 ☐ INTER-CHANGE LOOP RAMP	☐ 4 ☐ TIRES WORN	☐ 4 ☐ ICE	5 ☐ OTHER (SPECIFY)
6 ☐ DARK NO STREET LIGHT	☐ 5 ☐ RR SIGNAL	☐ 5 ☐ ALLEY	☐ 5 ☐ PUNCTURED OR BLOWN TIRES	☐ 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.

_____

I do hereby claim damages from the State of Washington in the sum of $_____.

A separate claim form should be submitted for each claimant. The Claimant must sign this claim form unless he or she is incapacitated, a minor, or a nonresident of the state, in which case it may be signed on behalf of the Claimant by any relative, attorney, or agent representing 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)*

FORM
S.F. 137
RMD EF 7/02

STATE OF WASHINGTON

VEHICLE ACCIDENT REPORT

Date of Accident (MM/DD/YYYY)	
Time	☐ AM ☐ PM

INSTRUCTIONS: This report must be mailed within two working days to the following offices:

① Office of Financial Management
Risk Management Division
300 General Administration Building
Post Office Box 41027, MS: 41027
Olympia, Washington 98504-1027

② Safety/Risk Management
Office of Reporting Agency

This report cannot be submitted electronically (via e-mail or fax)

STATE EMPLOYEE

DRIVER

Name	Age	Employing Agency	Position

Business Address / Zip	Business Phone	Email	Was vehicle being used on Official State Business? ☐ Yes ☐ No

Operator's License No.	License Restrictions ☐ Yes ☐ No	If Yes, Indicate	Have you had a previous accident while driving on state business? ☐ Yes ☐ No

VEHICLE NO. 1

License No.	Year	Make	Body Type	Where Located	No. of Passengers	Est. Repair Cost

Owning Agency	Describe Damages Fully (Parts, type, and extent of damage)

If Privately Owned, Name and Address of Owner (If State Owned, Equipment No. Only)	Insurer

OTHER VEHICLES

Owner Car No. 2	Phone	Owner Car No. 3	Phone

Address / City / Zip	Address / City / Zip

Driver	Age	Phone	Driver	Age	Phone

Address / City / Zip	Address / City / Zip

Driver's License No.	Vehicle License No.	Driver's License No.	Vehicle License No.

Vehicle Make	Year	Body Type	Vehicle Make	Year	Body Type

Name of Passengers	Name of Passengers

Repair Cost	Describe Damage	Repair Cost	Describe Damage

Insurance Company	Policy No.	Insurance Company	Policy No.

OTHER PROPERTY

What was Damaged?	Repair Cost

Name and Address of Owner / City / Zip	Phone

INJURED PARTIES

Name and Address	Extent of Injury	Age	Veh. 1	Veh. 2	Veh. 3	Ped.

WITNESSES

Name / Address / City / Zip	Phone

OTHER

Police Investigate? ☐ Yes ☐ No	Which Division (Sheriff, WSP, City)	Citation Issued? ☐ Yes ☐ No Issue To ☐ You ☐ Veh. 2 ☐ Veh. 3	Have you filed Financial Responsibility Form WSP 161 As Required by Law? ☐ Yes ☐ No

Location	Or Near Intersection of
City/County	Type of Accident ☐ Front to Rear ☐ Head-On ☐ Parked Car ☐ Pedestrian ☐ Broadside ☐ Sideswipe ☐ Bike - Car ☐ Hit Object

Information Regarding Accident	No. 1, Your Vehicle	No. 2, Other Party (Name)	No. 3, Other Party (Name)
1. If pedestrian, where was he/she (crosswalk, etc.)?			
2. Road conditions (dry, glare, icy, rain, snow, etc.)? (Gravel, blacktop, etc.)			
3. At what distance danger was first noticed?			
4. Speeds at time danger was first noticed?			
5. Speeds at time of accident?			
6. What warning signals were given?			
7. Obstruction to vision (weather and other)?			
8. Lights On? Wipers On? Windows Fogged?			
9. Had any party been drinking? Who?			

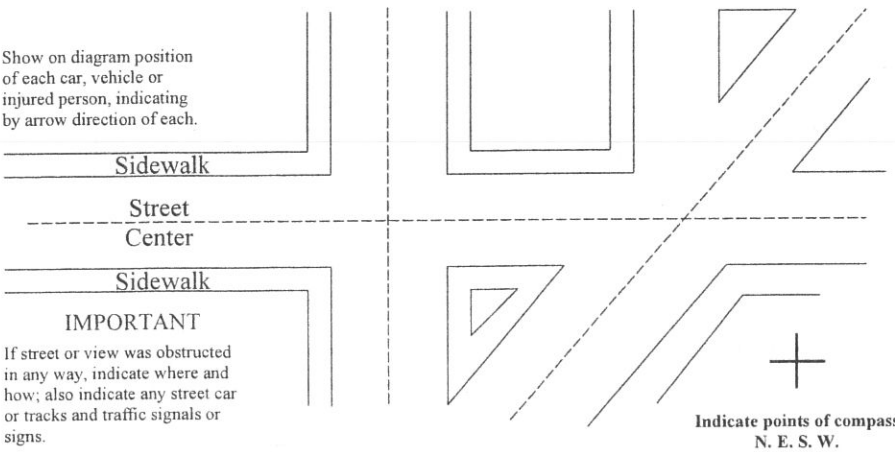
Describe in Detail What Happened (Use additional paper if necessary)

☐ Straight Road
☐ Curve – R or L
☐ Level

☐ Hillcrest
☐ Uphill
☐ Downhill

☐ One Lane
☐ One and One-Half Lane
☐ Two Lane or Four Lane

Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.

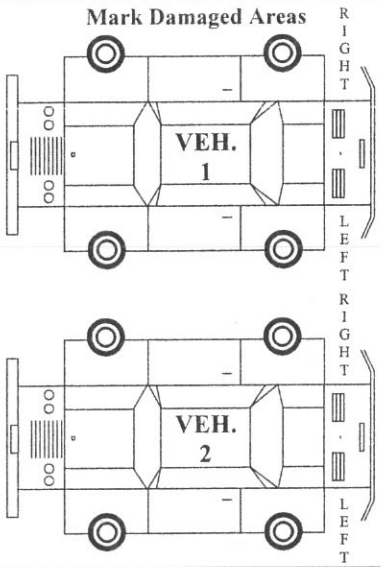


IMPORTANT

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.

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

Mark Damaged Areas



Signature (Driver)	Date	Signature (Supervisor)	Date

Form SF 137 (RMD Rev 06/04)