SKAGIT COUNTY PUBLIC HOSPITAL DISTRICT NO. 2
d/b/a ISLAND HOSPITAL

STANDARD TORT CLAIM FORM

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against the Skagit County Public Hospital District No. 2 d/b/a Island Hospital. Some of the information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure.

This form, which must be fully completed and properly signed, must be delivered as follows:

Mail or deliver original claim to:
Island Hospital
ATTN: Kimberly Graf, Executive Assistant to CEO, or
Liz Martin, Executive Secretary to CFO and CPCE
Administration Office
1211 24th Street
Anacortes, WA 98221

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

PLEASE TYPE OR PRINT CLEARLY IN INK

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 or cell

6. **Claimant's e-mail address:** _____

7. **Date of the incident:** _____ **Time:** _____ ☐ **am** ☐ **pm**
   (mm/dd/yyyy) **(check one)**

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

   From: _____ **Time:** _____ ☐ **am** ☐ **pm**
   (mm/dd/yyyy) **(check one)**

   To: _____ **Time:** _____ ☐ **am** ☐ **pm**
   (mm/dd/yyyy) **(check one)**

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. **Person, entity or department allegedly 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 employees of Skagit County Public Hospital District No. 2 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.**

_____

_____

_____

_____

_____

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_____

16. **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.**

_____

_____

_____

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

_____

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_____

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_____

_____

18. **Please attach documents which support the allegations of the claim.**

19. **I claim damages from Skagit County Public Hospital District No. 2 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)**
	OR
Signature of Representative	**Date and place (residential address, city and county)**
Print Name of Representative	**Bar Number (if applicable)**