Standard Tort Claim Form

General Liability Claim Form

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against Clallam County Public Hospital District No. 2 dba Olympic Medical Center. Some of the information on this form is required by RCW 4.92.100 and may be subject to public disclosure. Pursuant to law, Standard Tort Claim forms cannot be submitted electronically (via e-mail or fax).

For Official Use only
No.

PLEASE TYPE OR PRINT IN INK

Mail or Deliver Original Claim to:
Olympic Medical Center
Attention: Eric Lewis, CEO
939 Caroline Street
Port Angeles, WA 98362

Business Hours: 8:00am - 4:30pm Monday - Friday

CLAIMANT INFORMATION:

1. Claimants 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: ____-____-_____

6. Claimant's e-mail address: _____

INCIDENT INFORMATION:

7. Date of the incident: _____/_____/_____ Time: _____ AM PM
   (mm/dd/yyyy) (circle one)

8. If the incident occurred over a period of time, date of first and last occurrences:
   from ____/____/_____ Time: _____ AM PM to____/____/_____ Time _____ AM PM
   (circle one) (circle 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. Names, addresses and telephone numbers of all persons involved in or witness to this incident:

_____	_____-_____-_____	_____	_____-_____-_____
Name	Number	Name	Number
_____	_____-_____-_____	_____	_____-_____-_____
Name	Number	Name	Number
_____	_____-_____-_____	_____	_____-_____-_____
Name	Number	Name	Number

12. Names, addresses and telephone numbers of Medical Center employees having knowledge of this inciden

13. Names address and telephone numbers of all individuals not already identified in #11 and #12 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.

14. 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.

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

16. Names, address and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

17. Please attach documents which support the claim's allegations.

18. I claim damages from Olympic Medical Center in the sum of $_____.

This Standard Tort 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 the State of Washington on the Claimant's behalf, or by a court-appointed 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)