PUD No. 1 of Clallam County Standard Tort Claim Form Packet

Please *carefully read all of the information in this packet* before completing and presenting your Standard Tort Claim.

A New Law that Impacts Presenting a Standard Tort Claim Form

Engrossed Substitute House Bill 1553, effective July 26, 2009, requires citizens to present the Standard Tort Claim form to the agent for a local government entity. In compliance with these requirements and for the convenience of citizens, Public Utility District No. 1 of Clallam County (the "PUD") has developed a Standard Tort Claim Form Packet

Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Tort Claim Form
2. Standard Tort Claim Form
3. Medical Authorization
4. Vehicle Collision Form only 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

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

Mail:
PUD No. 1 of Clallam County
P.O. Box 1000
Carlsborg, WA 98324

In-person:
PUD No. 1 of Clallam County
104 Hooker Road
Sequim, WA 98382

Delivery may also be made in person to any PUD Customer Service office. (May vary by location.)

Closed on weekends and official state holidays.

PUD STANDARD TORT CLAIM FORM

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against Public Utility District No. 1 of Clallam County. 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 new law, Standard Tort Claim forms cannot be submitted electronically (via e-mail or fax).

PLEASE TYPE OR PRINT IN INK

Mail or deliver original claim to:

Mail:
PUD No. 1 of Clallam County
P.O. Box 1000
Carlsborg, WA 98324

In Person:
PUD No. 1 of Clallam County
104 Hooker Road
Sequim, WA 98382

FOR OFFICIAL USE ONLY

(Receiving employee to sign below, fill in date and time, and forward to Records Department)

Received by:_____

Date:_____ Time:_____

FOR OFFICIAL USE ONLY

Claim No. _____ *(Issued by Records Dept.)*

Records to route to Safety Administrative Assistant.

Or, deliver to any PUD Customer Service office. *(Hours may vary)*
Closed on weekends and official 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 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:_____ ☐ a.m. ☐ p.m.
(mm/dd/yyyy)

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

From:_____ Time:_____ ☐ a.m. ☐ p.m. To: _____ Time:_____ ☐ a.m. ☐ p.m.
(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. Department or individual 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 PUD employees having knowledge about this incident:

_____

_____

14. Names, address 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. 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 PUD 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 No._____

For Official Use Only

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) TO PUD NO. 1 OF CLALLAM COUNTY

Name:_____

(Last, First, Middle Initial or Middle Name)

Date of Birth: Month_____ Day_____ Year_____

I hereby authorize disclosure of my protected health information to Public Utility District No. 1 of Clallam County (the "PUD") for purposes of processing my claim for damages file with the PUD.

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

Pharmacy prescriptions and reports

All letters and memos received or sent, including electronic mail, referencing any 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 the PUD and not protected for purposes of evaluating and investigating the claim I have filed with PUD No. 1 of Clallam County

_____ 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 the PUD in writing, and that the revocation will be effective as of the date the PUD 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 fro 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 PUD.

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

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 (marked “CONFIDENTIAL”) to:

Safety Administrative Assistant
PUD No. 1 of Clallam County
P.O. Box 1000
Carlsborg, WA 98324

VEHICLE COLLISION FORM

PLESE 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/YYY)	TIME AM ☐ PM ☐
CURRENT STREET (RESIDENCE) ADDRESS	CITY	STATE	ZIP		PHONE HOME WORK
(RESIDENCE) STREEET ADDRESS FOR SIX MONTHS PRIOR TO 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/LOCAL 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	VEH1	VEH2	VEH3	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.

Sidewalk

Street

Center

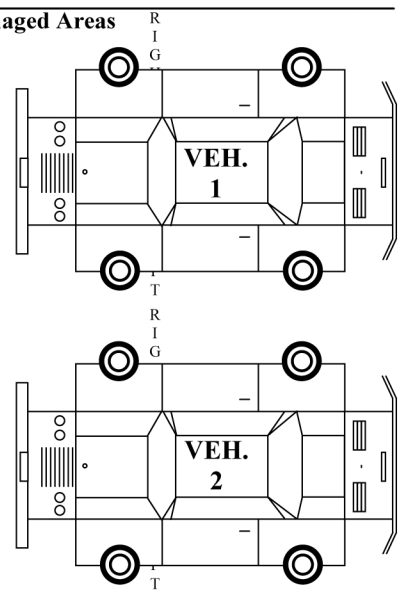
Sidewalk

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		NAME OF INVESTIGATING POLICE AGENCY: _____	
	☐ 8 ☐ NO TRAFFIC CONTROL	☐ 2 ☐ DIVIDED		INVESTIGATING AGENCY REPORT NO. _____	
	☐ 9 ☐ OTHER	☐ 3 ☐ 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)***