

# Standard Tort Claim Form Packet

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

## Presenting a Standard Tort Claim Form

RCW 4.96.020 requires citizens to present the Standard Tort Claim form with the government agency named in their claim. The law also requires State and local government agencies to post the Standard Tort Claim form on their website with instructions on how to complete the form. In compliance with these requirements and for the convenience of citizens, The State Office of Financial Management (OFM) 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 (SF 210)
3. Authorization for Release of Protected Health Information
4. Vehicle Collision Form (SF 138) - for tort claims involving vehicle accidents or 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:

Lynden School District  
Attention: Superintendent  
516 Main St.  
Lynden, WA 98264

Business Hours: Monday-Friday, 7:30 a.m. to 4:00 p.m.  
Closed on weekends and holidays.

## Instructions for Completing a Standard Tort Claim Form (SF 210)

- Before filing a Standard Tort Claim form, please read these instructions, the Standard Tort Claim form and other appropriate forms in their entirety.
- Type or print clearly in ink and sign the Standard 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 Standard Tort Claim form can be easily read and understood.

The following are *examples* on how to complete the Standard Tort Claim Form (SF 210):

- 1) Smith, Karen Michelle – 02/20/1965
  - 2) 1234 Front Street, Apt. 123, Lynden WA 98264
  - 3) PO Box 910, Lynden WA 98264
  - 4) Same (or residence at the time of incident)
  - 5) (360) 123-4567
  - 6) KMSmith@hotmail.com
  - 7) 08/09/2010 8:00 a.m.
  - 8) 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
  - 9) Washington, Whatcom, Lynden, Lynden High School, Room 123
  - 10) If applicable, I-5, Southbound, Milepost 255, near the Sunset Drive Exit
  - 11) Lynden School District
  - 12) Smith, Jane Marie, 1234 Front St., Apt. 11, Lynden WA 98264 (360) 123-4567
  - 13) Unknown
  - 14) List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed in #12 and #13. 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.
  - 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 names, addresses, telephone numbers and the type of treatment of all your medical providers. If you were treated for a personal injury, please include your medical records and bills.
  - 18) Please attach any additional documents that support your claim.
  - 19) 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 Authorization for Release of Protected Health Information form.
  - If your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision 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 Lynden School District. Some of the information requested on this form is required by RCW 4.92.100 and may be subject to public disclosure. Standard Tort Claim forms cannot be submitted electronically (via email or fax).

**PLEASE TYPE OR PRINT IN INK**

**Mail or deliver to:** Lynden School District #504  
Attention: Superintendent  
516 Main St.  
Lynden, Washington 98264

Business Hours: Monday – Friday 7:30 a.m. – 4:00 p.m.  
Closed on weekends and holidays.

1. Claimant's name: \_\_\_\_\_  

Last name	First	Middle	Date of birth (mm/dd/yyyy)
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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
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6. Claimant's e-mail address: \_\_\_\_\_
7. Date of the incident: \_\_\_\_\_ Time: \_\_\_\_\_ AM PM (check one)  
(mm/dd/yyyy)
8. If the incident occurred over a period of time, date of first and last occurrences:  
from \_\_\_\_\_ Time: \_\_\_\_\_ AM PM through \_\_\_\_\_ Time: \_\_\_\_\_ AM PM  
(mm/dd/yyyy) (mm/dd/yyyy)
9. Location of incident: \_\_\_\_\_  

State and county	City, if applicable	Place where occurred
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10. If the incident occurred on a street or highway:  

Name of street or highway	Milepost number	Nearest intersecting street
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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 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.

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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.

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

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

19. I claim damages from the Lynden School District 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 country)

Or

\_\_\_\_\_  
Signature of Representative

\_\_\_\_\_  
Date and place (residential address, city and country)

\_\_\_\_\_  
Print Name of Representative

\_\_\_\_\_  
Bar Number (if applicable)

**Authorization for Release of Protected Health Information (PHI)**  
**to**  
**Lynden School District**  
**Attention: Superintendent**

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Name: \_\_\_\_\_  
(Last, First, Middle Initial or Middle Name)

Date of Birth: \_\_\_\_\_  
(mm/dd/yyyy)

I hereby authorize disclosure of my protected health information to the Lynden School District 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 or 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 records generated for or by governmental programs of which I am a client. Identify the program(s) and agency:

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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 Washington  
Initials State Health Care Information Act (RCW 70.02).

\_\_\_\_\_ I understand that my health information may be subject to re-disclosure by Lynden School District #504 and  
Initials not protected for purposes of evaluating and investigating the claim I have filed with Lynden School District.

\_\_\_\_\_ I understand that the specific information to be disclosed in my medical record may include information  
Initials 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 Lynden School District in  
Initials writing, and that the revocation will be effective as of the date Lynden School District 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  
Initials a different time frame for this release to be valid. This permission is valid until my claim is resolved or closed  
by Lynden School District.

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*A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to Lynden School District.*

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

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### To the Provider or Records Custodian:

Please send legible copies of all records to:

Lynden School District  
Attention: Superintendent  
516 Main Street  
Lynden, WA 98264

# 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.

<b>CLAIMANT AND INCIDENT INFORMATION</b>	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	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					
<b>YOUR VEHICLE INFORMATION (VEHICLE #1)</b>	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.			
<b>OTHER VEHICLE INFORMATION (VEHICLE #2)</b>	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 \$		
<b>OTHER NON-VEHICLE DAMAGE</b>	WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.									
	NAME OF OWNER			ADDRESS	CITY	PHONE				
	DESCRIBE DAMAGE							ESTIMATE \$		
<b>INJURED PARTIES</b>	NAME	ADDRESS	PHONE	INJURY	AGE	VEH 1	VEH 2	VEH 3	PED	OTH
				HOME WORK						
				HOME WORK						
				HOME WORK						
				HOME WORK						
				HOME WORK						
<b>WITNESSES</b>	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.

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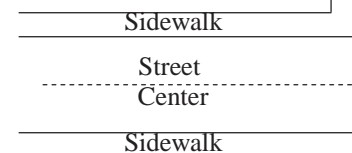
- Straight Road
- Curve – R or L
- Level

- Hillcrest
- Uphill
- Downhill

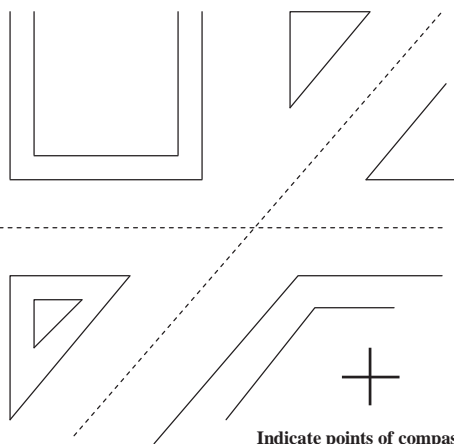
- One Lane
- One and One-Half Lane
- Two Lane or Four Lane

**Mark Damaged Areas**

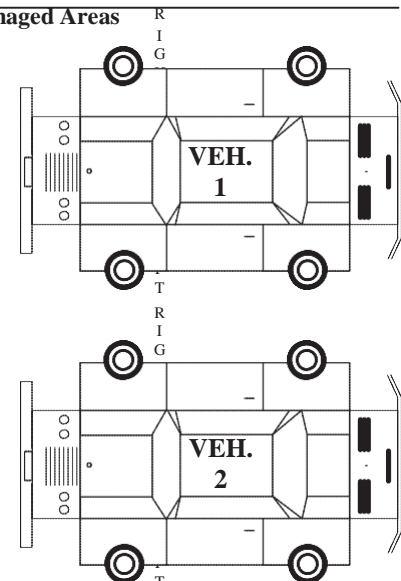
Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.



**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.



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		
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			
	<input type="checkbox"/> 8 <input type="checkbox"/> NO TRAFFIC CONTROL	<input type="checkbox"/> 2 <input type="checkbox"/> DIVIDED			
	<input type="checkbox"/> 9 <input type="checkbox"/> OTHER	<input type="checkbox"/> 3 <input type="checkbox"/> UNDIVIDED			
					NAME OF INVESTIGATING POLICE AGENCY:
					INVESTIGATING AGENCY REPORT NO.

**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)*