

## INSTRUCTIONS FOR FILING A CLAIM AGAINST GRAYS HARBOR COUNTY

- ✓ Before filing this claim, please read the instructions in their entirety.
- ✓ Type or print **clearly** in ink and sign the tort claim form. **Do not staple or tape documents**. Do not put claim form in binders or add divider tabs as all documents must be scanned.
- ✓ Provide all requested information and any available documents or evidence supporting your claim, such as medical records or bills for damages, 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.
  
- ✓ NOTE: The claim form and supporting documents are subject to disclosure through the Public Records Act (RCW Chapter 42.56).
  
- ✓ The following are *examples* on how to complete the tort claim form:
  - 1) Smith, Karen Michelle – 02/20/1965
  - 2) #809234 (for use by inmates only)
  - 3) 100 W. Broadway, Suite 33 Montesano, WA 98563
  - 4) PO Box 9100, Montesano, WA 98563
  - 5) Same (or residence at the time of incident)
  - 6) Claimant's phone number(s) w/ area code
  - 7) Claimant's or Representative's email address
  - 8) 8/9/2010 8:00 a.m.,
  - 9) If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item 8.
  - 10) Washington, Grays Harbor County, Ocean Shores, beach.
  - 11) Highway 12 - Milepost 5 - Monsanto, WA
  - 12) Sheriff's office
  - 13) Smith, John Doe, 1234 Blank Way NW, Apt. 56, Elma, WA 93215 (360) 456-XXXX; Tow Truck Driver, Nisqually Towing
  - 14) List any GHC employees who have knowledge about the incident in question.
  - 15) List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items 13 and 14. 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.
  - 16) Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.
  - 17) 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 and the report or incident number.
  - 18) 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.
  - 19) Please include any additional documents that support your claim.
  - 20) 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 your claim involves a motor vehicle accident, please complete, sign, and include the vehicle accident form.**

## Grays Harbor County Tort Claim Form

Pursuant to RCW 4.96.020, this form is for filing a tort claim against Grays Harbor County. Some of the information requested on this form is required by RCW 4.92.100 and may be subject to public disclosure.

**PLEASE TYPE OR PRINT CLEARLY IN INK**

**Mail or deliver claim to:** Attn: Risk Management  
100 W. Broadway Suite #32  
Montesano, WA 98563

**Email the claim to:** GHCRiskManagement@co.grays-harbor.wa.us

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

1. Claimant's name: \_\_\_\_\_  
Last name                      First                      Middle                      Date of birth (mm/dd/yyyy)
2. Inmate number (if applicable): \_\_\_\_\_
3. Current residential address: \_\_\_\_\_
4. Mailing address (if different): \_\_\_\_\_
5. Residential address at the time of the incident: \_\_\_\_\_  
(if different from current address)
6. Claimant's daytime telephone number: \_\_\_\_\_  
Home    Business or Cell
7. Claimant's e-mail address: \_\_\_\_\_
8. Date of the incident: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m. (check one)  
(mm/dd/yyyy)
9. If the incident occurred over a period of time, date of first and last occurrences:  
from \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
(mm/dd/yyyy)                      (mm/dd/yyyy)  
to \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
(mm/dd/yyyy)                      (mm/dd/yyyy)
10. Location of incident: \_\_\_\_\_  
State and county                      City, if applicable                      Place where occurred

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

Name of street or highway	Milepost number	At the intersection with or nearest intersecting street
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12. Grays Harbor County department alleged responsible for damage/injury:

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13. Names, addresses and telephone numbers of all persons involved in or witness to this incident:

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14. Names, addresses and telephone numbers of all county employees having knowledge about this incident:

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15. Names, addresses and telephone numbers of all individuals not already identified in #13 and #14 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. Include additional sheets if necessary.

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16. Describe the cause of the injury or damages. Explain the extent of property loss or medical, physical or mental injuries. Include additional sheets if necessary.

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17. Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom? Please include a copy of the report or contact information.

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18. Names, addresses and telephone numbers of treating medical providers. Include copies of all medical reports and billings.

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19. Please include documents which support the allegations of the claim.

20. I claim damages from Grays Harbor County 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)**

# VEHICLE COLLISION FORM

PLEASE TYPE OR PRINT IN INK

Please include this form to your standard tort claim form, if the claim involves a vehicle collision.

<b>CLAIMANT AND INCIDENT INFORMATION</b>	CLAIMANT'S NAME <b>(A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)</b>				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 include property damage estimates and/or all medical bills in support of your claim. If necessary, include additional pages containing information in this format.

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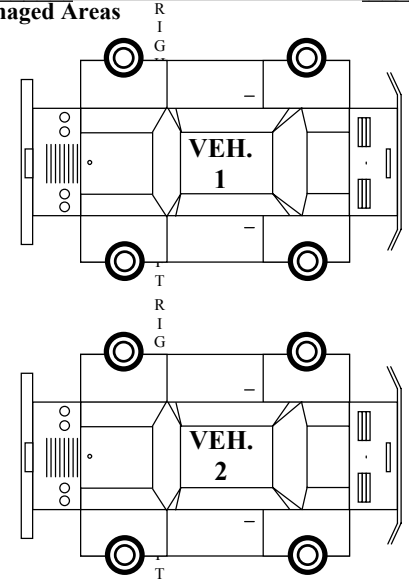
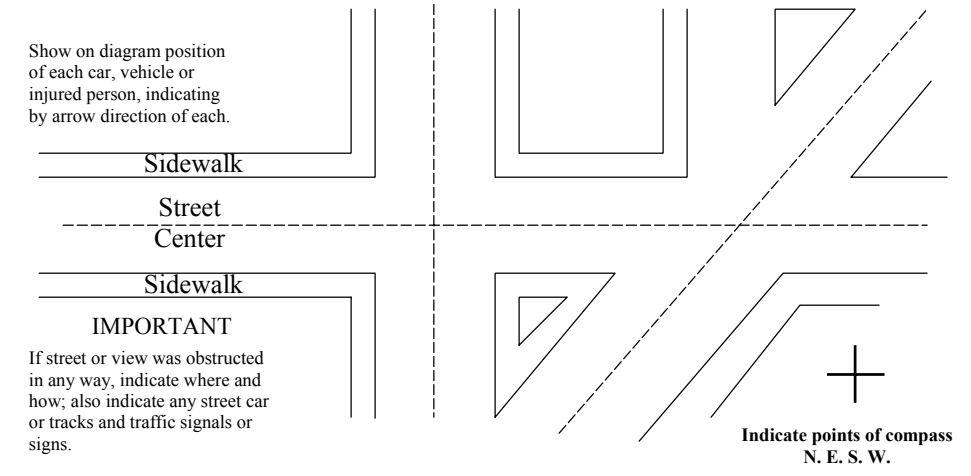


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|---|------------------------------------|--|
| <input type="checkbox"/> Straight Road  | <input type="checkbox"/> Hillcrest | <input type="checkbox"/> One Lane              |
| <input type="checkbox"/> Curve – R or L | <input type="checkbox"/> Uphill    | <input type="checkbox"/> One and One-Half Lane |
| <input type="checkbox"/> Level          | <input type="checkbox"/> Downhill  | <input type="checkbox"/> Two Lane or Four Lane |



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 <input type="checkbox"/> 1 <input type="checkbox"/> SIGNALS	VEHICLE NO. 1 NO. 2 <input type="checkbox"/> 1 <input type="checkbox"/> ONE WAY	VEHICLE NO. 1 NO. 2 <input type="checkbox"/> 1 <input type="checkbox"/> DEFECTIVE BRAKES	VEHICLE NO. 1 NO. 2 <input type="checkbox"/> 1 <input type="checkbox"/> DRY	1 <input type="checkbox"/> CLEAR, CLOUDY & OVERCAST
2 <input type="checkbox"/> DAWN	<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	2 <input type="checkbox"/> RAINING
3 <input type="checkbox"/> DUSK	<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	3 <input type="checkbox"/> SNOWING
4 <input type="checkbox"/> DARK STREET LIGHTS ON	<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	4 <input type="checkbox"/> FOG
5 <input type="checkbox"/> DARK STREET LIGHTS OFF	<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	<input type="checkbox"/> 5 <input type="checkbox"/> OTHER (SPECIFY)	5 <input type="checkbox"/> OTHER (SPECIFY)
6 <input type="checkbox"/> DARK NO STREET LIGHT	<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)	NAME OF INVESTIGATING POLICE AGENCY: _____ INVESTIGATING AGENCY REPORT NO. _____	
7 <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			

“  
**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)*