WhidbeyHealth

WhidbeyHealth Hospice
101 N. Main Street, Coupeville, WA 98239
(360) 914-5635 · FAX (360) 678-1013
whidbeyhealth.org

WHIDBEY ISLAND PUBLIC HOSPITAL DISTRICT, ISLAND COUNTY, WASHINGTON TORT CLAIM FORM

For Official Use Only

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against Whidbey Island Public Hospital District, Island County, Washington, d/b/a WhidbeyHealth (the "District"). Some of the information requested on this form is required by RCW 4.96.020 and is subject to public disclosure pursuant to RCW 42.56.

PLEASE TYPE OR PRINT CLEARLY IN INK

Mail or deliver original claim to

Director of Quality &
Transformation/Compliance Officer
Attn: Shanna Harney-Bates
Whidbey Island Public Hospital District,
Island County, Washington
d/b/a WhidbeyHealth
WhidbeyHealth Medical Center
101 North Main Street,
Coupeville, WA - 98239-3413

Business Hours: Monday – Friday 8:30 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 DOC 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

12. District department you believe is responsible for damage/injury:

____

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

____

____

____

14. Names and telephone numbers of all District employees having knowledge about this incident:

____

____

15. Names 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. Attach additional sheets if necessary.

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16. Describe how the District caused your injuries or damages (**if your injuries or damages were not caused by the District, do not use this form. You must file your claim against the correct entity**). Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.

____
____
____
____
____
____
____
____

17. 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.

____
____
____

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

____
____
____
____

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

20. I claim damages from the District in the sum of $____________.

This Claim form must be signed by one of the following (check appropriate box).

- ☐ Claimant
- ☐ Person holding a written power of attorney from the Claimant
- ☐ Attorney in fact for the Claimant
- ☐ Attorney admitted to practice in Washington State on the Claimant's behalf
- ☐ 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)*