



Tort Claim Form Packet

Please carefully read all of the information in this packet before completing and presenting your tort claim forms and supporting documentation to the Port of Longview. Tort claims are subject to public disclosure pursuant to RCW 42.56

Standard Tort Claim Forms

Chapter 4.96 RCW requires the Port of Longview to receive and process citizen's standard tort claims against the Port of Longview. State law requires an original signature on the Tort Claim Form. As such, tort claim forms cannot be submitted electronically, but must be presented in person or received by mail.

Documents contained in the Tort Claim Form Packet include instructions for completing the Standard Tort Claim Form, a Standard Tort Claim Form, and an Authorization for Release of Protected Health Information to the Port of Longview.

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
- Court-approved guardian or guardian ad litem on behalf of the Claimant

Tort Claim Form Submission

Present the completed form and supporting documents in person or by mail to the Port of Longview at the following address:

Port Auditor: Jaime Thayer
Port of Longview
10 International Way
Longview, WA 98632

Business Hours: Monday through Friday 8:00 a.m. to 5:00 p.m.
Closed weekends and holidays

Port of Longview will generally acknowledge receipt of a Standard Tort Claim by letter to the Claimant within 10 business days of receipt of the claim. For claim follow-up or acknowledgement questions, call 360-425-3305.



Instructions for Completing a Tort Claim Form

Before filing a Tort Claim, 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 repairs, wage loss information, and other documentation as appropriate.
- If the requested information cannot be supplied in the space provide, please use additional blank sheets so your Standard Tort Claim Form can be easily read and understood.
- State law requires an original signature on the Standard Tort Claim Form. This means the form cannot be submitted electronically (fax or email).
- If you are presenting a personal injury claim, please sign and attach the Authorization for Release of Protected Health Information to the Port of Longview.
- If the incident that caused damages occurred over a period of time, please provide the beginning and ending date.
- Once the Standard Tort Claim Form is completed, and supporting documentation is collected, present in person or by mail to:

Port Auditor: Jaime Thayer
Port of Longview
10 International Way
Longview, WA 98632

Business Hours: Monday through Friday 8:00 a.m. to 5:00 p.m.
Closed weekends and holidays

- The length of the Standard Tort Claim investigation varies greatly depending on the complexity of the issues and the availability of documents and witnesses to support causation and damages. A Standard Tort Claim can be resolved and closed quicker when all relevant information and documents are provided initially for the investigator's consideration.
- Port of Longview will generally acknowledge receipt of a Standard Tort Claim by letter to the Claimant within 10 business days of receipt of the claim. For claim follow-up or acknowledgement questions, call 360-425-3305.



Standard Tort Claim Form

General Liability Claim Form

For Official Use Only
Received date: _____
Claim no. _____

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against the Port of Longview. Some of the information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure. Pursuant to law, this tort claim cannot be submitted electronically (via email or fax).

PLEASE TYPE OR PRINT IN INK

Mail or deliver original claim to: Port Auditor: Jaime Thayer
Port of Longview
10 International Way
Longview, WA 98632

Business Hours: Monday through Friday 8:00 a.m. to 5:00 p.m.
Closed weekends and holidays

Claimant Information

1. Claimant's name: _____
Last First Middle
2. Date of birth: _____
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
7. Claimant's email address: _____

Incident Information

8. Date of incident: _____ Time of incident: _____
9. If the incident occurred over a period of time, date of first and last occurrences:
From (date) _____ Time: _____
To (date) _____ Time: _____
10. Location of incident: _____
State and County City, if applicable Place where occurred

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

<i>Name of street or highway</i>	<i>Milepost number</i>	<i>Intersection Name</i>
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12. Names, addresses, and telephone numbers, if known, of all persons involved in or witness to this incident: _____

13. Names, addresses, and telephone numbers, if known, of all Port employees having knowledge about this incident if known: _____

14. Names, addresses, and telephone numbers, if known, 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.

15. Describe how the Port of Longview caused your injuries or damages. (If your injuries or damages were not caused by the Port of Longview, do not use this form. You must file your claim against the correct entity). 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 Port of Longview 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 the 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, & county)

Or

Signature of Representative

Date and place (residential address, city, & county)

Printed Name of Representative

WSBA # (if applicable)



Authorization for Release of Protected Health Information (PHI) to the Port of Longview

Full name: _____

Date of birth: _____

I hereby authorize disclosure of my protected health information for the purpose of processing my claim for damages filed with the Port of Longview. Please send legible copies of all records to:

Port Auditor: Jaime Thayer
Port of Longview
10 International Way
Longview, WA 98632

I understand that by signing this document, I authorize the release of the following information:

- Complete medical records 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 physical assistant orders; nursing notes; and all other records and references designated by the provider as part of its medical record.
- HIV test results and information related to HIV testing and/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 and/or treatment records.
- All other chemical dependency assessment of treatment records.
- Pharmacy prescriptions and reports.
- All correspondence and documents received or sent, including electronic mail, referencing my treatment, information related to alleged sexual assault or sexually transmitted disease, including test results.
- Gynecological and/or obstetrical information.
- Urgent care, outpatient and other clinic visit information.
- All client records generated for or by governmental programs of which I am a client. Identify the programs(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 Port of Longview and not protected for purposes of evaluating and investigating the claim I have filed with the Port of Longview.

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 that I may revoke this authorization at any time by notifying the Port of Longview's Port Auditor, Jaime Thayer, in writing, and that the revocation will be effective as of the date received by the Port of Longview's Port Auditor, Jaime Thayer. Any records obtained pursuant to this Authorization for Release of Protected Health Information prior to the revocation will be deemed authorized by me for release.

Initials I understand that this Authorization for Release will expire ninety (90) days from 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 by the Port of Longview.

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

Signature of Authorizing Individual

Date

Telephone Number

Witness (where patient is over 13 and signing the release): _____

Where the signer is not the subject of records:

I am authorized to sign this because I am the (attach proof of authority): _____

- Parent of minor
- Legal Guardian
- Personal Representative
- Other: _____

VEHICLE COLLISION FORM

PLEASE TYPE OR PRINT IN INK

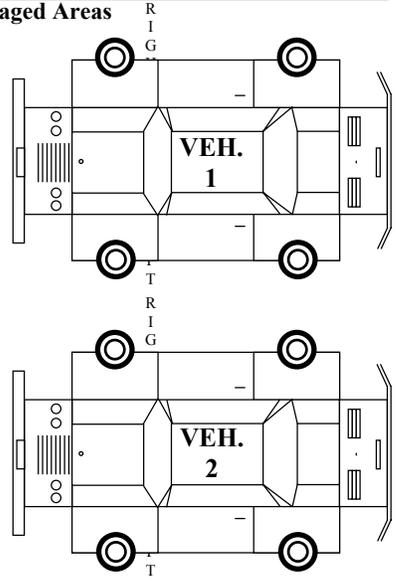
Please attach this form to your standard tort claim form, if the claim involves a vehicle collision.

CLAIMANT AND INCIDENT INFORMATION	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					
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 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	VEH 1	VEH 2	VEH 3	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			

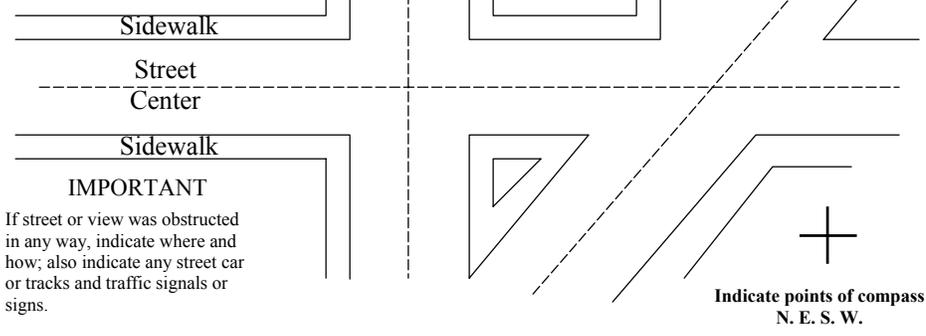
COMPLETE ALL DETAILS

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.

- | | | |
|---|------------------------------------|--|
| <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 |



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



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	<input type="checkbox"/> 5 <input type="checkbox"/> OTHER (SPECIFY)	
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		NAME OF INVESTIGATING POLICE AGENCY:	
	<input type="checkbox"/> 8 <input type="checkbox"/> NO TRAFFIC CONTROL	<input type="checkbox"/> 2 <input type="checkbox"/> DIVIDED		INVESTIGATING AGENCY REPORT NO.	
	<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)