Mid-Valley Hospital & Clinic

Standard Tort Claim Form

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against Okanogan County Public Hospital District #3. Some of the information on this form is required by RCW 4.92.100 and may be subject to public disclosure.

PLEASE TYPE OR PRINT IN INK

Mail or deliver original claim to:

Okanogan County Public Hospital District #3
d/b/a Mid Valley Hospital
Attn: Risk Management
810 Jasmine Street
Omak, WA 98841

Business Hours are Monday-Friday 8:00am-4:30pm
Fax: 509-826-7379 Phone: 509-861-2525

CLAIMANT INFORMATION:

1. Claimants 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: _____ AM PM
   (mm/dd/yyyy) (circle one)
8. If the incident occurred over a period of time, date of first and last occurrences:
   from ____/____/_____ Time: _____ AM PM to____/____/_____ Time _____ AM PM
   (circle one) (circle one)
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. Names, addresses and telephone numbers of all persons involved in or witness to this incident:
    (Attach additional sheets if necessary)

_____ Name	_____-_____-_____ Number	_____ Name	_____-_____-_____ Number
_____ Name	_____-_____-_____ Number	_____ Name	_____-_____-_____ Number
_____ Name	_____-_____-_____ Number	_____ Name	_____-_____-_____ Number

12. Names, addresses and telephone numbers of Hospital employees having knowledge of this incident.

_____
_____

13. Names address and telephone numbers of all individuals not already identified in #11 and #12 above that have knowledge regarding the 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)

_____
_____
_____
_____
_____

14. 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)

_____
_____
_____
_____
_____

15. 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.

_____
_____
_____

16. Names, address and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

_____
_____
_____

17. Please attach documents which support the claim's allegations.

18. I claim damages from Mid Valley Hospital District in the sum of $_____.

This Tort 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 the State of Washington on the Claimant's behalf, or by a court-appointed 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)