GCHD
GRANT COUNTY HEALTH DISTRICT

1038 West Ivy, Suite 1
Moses Lake, WA 98837

TORT CLAIM FORM

Complete the Tort Claim Form giving specific details about your damage or loss. Please type or print legibly. Include dates, times, and relevant witness information. It is to your advantage to also present with your claim relevant supporting documents (receipts, canceled checks, estimates, billings, etc.) or additional evidence (photos, diagrams, etc.). Attach additional sheets if necessary to describe the requested information. Sign and date the completed form and mail or deliver it to:

Theresa Adkinson, Administrator
Grant County Health District
1038 Ivy Street Suite 1
Moses Lake, WA 98837

Between the hours of 8:00 am and 5:00pm, Monday through Thursday

NOTICE: No damages can be paid by the Grant County Health District (GCHD) unless a claim complying with Washington State Law is presented to the Administrator. All submitted documents are subject to the Washington State public records act. The submitted form must contain an original signature. Copies, facsimiles or forms without an original signature will be rejected.

CLAIMANT INFORMATION

Claimant's Name:_____ **Date of Birth:**_____

Current Residential Address:_____

Home Phone:_____ **Business Phone:**_____ **Email Address:**_____

INCIDENT INFORMATION

Your Address at Time of Incident:_____

Date of Incident: _____ **Time of Incident:**_____ **Amount Claimed: $**_____

Address/Location of Incident:_____

Describe the Incident:

GCHD's Involvement (if possible, please identify employee and/or department involved):

Has the Incident been reported to law enforcement, safety, or security personnel? (please identify entity, agent, and time of report):

Witnesses (please provide addresses and phone numbers):

(1)	**(2)**	**(3)**

Property Damage (please describe the value and extent of the damage to your home, automobile, or personal property. Attach estimates, bills, or whatever documentation of damages you may have):

Claimant's Vehicle Information (if applicable):

Make: _____ **Model:** _____ **Year:** _____ **License Number:** _____

Insurer's Name: _____ **Policy Number:** _____

Were you injured? ☐ **No** ☐ **Yes** **If yes, then complete the following:**

Describe your injury [Identify your doctor(s)/healthcare provider(s)]:

Are you still receiving medical treatment? ☐ **No** ☐ **Yes**

Employer:_____ **Employer's Phone:**_____

Employer's Address:_____

Wage Loss? ☐ **No** ☐ **Yes If Yes, rate of pay:**_____ **Type of work:**_____

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."

_____ _____

Date **Signature**

_____

City, State