STANDARD TORT CLAIM FORM
PLEASE TYPE OR PRINT IN INK

General Liability Claim Form
Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against the Public Utility District No. 3 of Mason County. Some of the information requested on this form is required by RCW 4.92.100 and may be subject to public disclosure. Pursuant to the law, Standard Tort Claim forms cannot be submitted electronically (via email or fax).
For Official Use Only

Mail or deliver original claim to:

Brian Taylor
Auditor/Risk Manager
PO Box 2148
Shelton, WA 98584

Business Hours: Monday - Friday 8:00 a.m. - 5:00 p.m.
Telephone Number: 360-426-8255 ext. 5213
Closed on weekends and official state holidays.

PERSONAL INFORMATION

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 TIME OF INCIDENT:
   (if different from current address)

   _____

6. CLAIMANT'S DAYTIME TELEPHONE: (___)_____ (___)_____
   Home Business or Cell

7. CLAIMANT'S EMAIL ADDRESS: _____

INCIDENT INFORMATION

8. DATE OF INCIDENT: _____ TIME: _____ [ ] a.m. [ ] p.m. (check one)
   (mm/dd/yyyy)

9. IF THE INCIDENT OCCURRED OVER A PERIOD OF TIME, PLEASE PROVIDE DATES:

   FROM _____ TIME _____ [ ] a.m. [ ] p.m. (check one)
   (mm/dd/yyyy)

   TO _____ TIME _____ [ ] a.m. [ ] p.m. (check one)
   (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 St.

12. AGENCY OR DEPARTMENT ALLEGED RESPONSIBLE FOR DAMAGE/INJURY: _____

13. NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ALL PERSONS INVOLVED IN OR WITNESS TO THIS INCIDENT:

    _____
    _____
    _____
    _____

14. NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ALL DISTRICT EMPLOYEES HAVING KNOWLEDGE ABOUT THIS INCIDENT:

    _____
    _____
    _____
    _____

15. NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ALL INDIVIDUALS NOT ALREADY IDENTIFIED IN #13 AND #14 ABOUT THAT HAVE KNOWLEDGE REGARDING THE LIABILITY ISSUES INVOLVED IN THIS INCIDENT, OR KNOWLEDGE OF 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). _____
    _____
    _____
    _____

16. DESCRIBE THE CAUSE OF INJURYOR DAMAGES. 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. PLEASE ATTACH COPIES OF ALL MEDICAL REPORTS AND BILLINGS.

_____
_____
_____

19. PLEASE ATTACH DOCUMENTS WHICH SUPPORT THE ALLEGATIONS OF THIS CLAIM.

20. I CLAIM DAMAGES FROM MASON COUNTY PUD NO. 3 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 ATTORNEYADMITTED 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)

Authorization for Release of Protected Health Information (PHI)
To Mason County Public Utility District No. 3

Name: _____ _____ _____ Date of Birth: _____
Last name First Middle (mm/dd/yyyy)

I hereby authorize disclosure of my protected health information to the Department of Enterprise Services, Office of Risk Management (Risk Management) for purposes of processing my claim for damages filed with the state of Washington.

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

Complete medical record 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 physician assistant orders; nursing notes; and all other records and references designated by the provider as part of its medical record.

HIV Test Results and medical information related to HIV testing 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 or treatment records

All other chemical dependency assessment of treatment records Pharmacy prescriptions and reports

All letters and memos received or sent, including electronic mail, referencing my treatment, compliance with treatment and any other subject related to my medical treatment

Information related to alleged sexual assault or sexually transmitted disease, including test results Urgent care, outpatient or other clinic visit information

Gynecological and/or obstetrical information

All client records generated for or by governmental programs of which I am a client. Identify the program(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 HIPAAIPHI 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 PUD No. 3 and not protected for purposes of evaluating and investigating the claim I have filed with PUD No. 3.

_____ 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 I may revoke this authorization at any time by notifying PUD No. 3 in writing, and that the revocation will be effective as of the date PUD No. 3 receives any records obtained pursuant to this Authorization for Release of PHI prior to the revocation will be deemed authorized by me for release.

_____ Initials I understand that this Authorization for Release will expire 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 or closed by PUD No. 3.

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to PUD No. 3.

Signature of Authorizing Individual:

_____

Date of Signature: _____

Telephone number: _____

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

_____

Where the signer is not the subject of the records:
I am authorized to sign this because I am the (attach proof of authority):

- □ Parent of minor
- □ Legal Guardian
- □ Personal Representative
- □ Other

To the Provider or Records Custodian:

Please send legible copies of all records to:

Brian Taylor
Auditor /Risk Manager
PO Box 2148
Shelton, WA 98584