

Standard Forms Packet for Claims Against Port of Friday Harbor, Washington

Please *carefully read all of the information in this packet* before completing and presenting your Standard Tort Claim.

Law that Impacts Presenting a Standard Tort Claim Form

RCW 4.96.020 requires claimants to present the Standard Tort Claim form with the Port of Friday Harbor. In compliance with these requirements and for the convenience of citizens, the Port and the state have developed the Standard Tort Claim Form Packet.

Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Tort Claim Form
2. Standard Tort Claim Form
3. Medical Authorization
4. Vehicle Collision Form only for tort claims involving vehicle accidents/collisions

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
- A court-approved guardian or guardian ad litem on behalf of the Claimant.

File in Person or Mail the Standard Tort Claim Form and Supporting Documents to:

Mail to:

Port of Friday Harbor
Attn: Phyllis Johnson
P.O. Box 889
Friday Harbor, WA 98250

Deliver to:

Port of Friday Harbor
Attn: Phyllis Johnson
204 Front Street
Friday Harbor, WA 98250

Business Hours: Monday-Friday, 8:00 a.m. to 5:00 p.m.
Closed on weekends and official state holidays.

INSTRUCTIONS FOR COMPLETING A STANDARD TORT CLAIM FORM

- Before presenting a Standard Tort Claim form, 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 property value, etc.
- If the requested information cannot be supplied in the space provided, please use additional blank sheets so your Standard Tort Claim form can be easily read and understood.
- The following are examples of how to complete the Standard Tort Claim Form:
 1. Smith, Karen Michelle
 2. 1234 College Way NW, Apt. 56, Seattle WA 98178
 3. PO Box 910, Seattle WA 98178
 4. Same (or residence at the time of incident)
 5. 206-123-4567
 6. 8:00 a.m., August 9, 2008
 7. If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item 7
 8. Washington, Thurston, Tumwater, Campus of South Puget Sound Community College, Building number 22
 9. I-5, Southbound, Milepost 109, near the Martin Way Exit
 10. Washington State Department of Transportation, Highway
 11. Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Seattle WA 98178 (360) 456-3456; Tow Truck Driver, Nisqually Towing
 12. Unknown
 13. List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items 11 and 12. Also include a description of their knowledge. For example, if your sister was with you, when the alleged incident occurred, please include her name, address, telephone number, and indicate she witnessed the incident.
 14. Please provide all of your medical providers with their names, address, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include your medical records and bills.
 15. Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.
 16. If you reported this incident to law enforcement, safety, or security personnel, please provide a copy of the report or contact information to the person you spoke with.
 17. Please provide the dollar amount for your damages, including your time loss, medical costs, property damage loss, etc. This amount should represent your opinion of total compensation.
- If you are presenting a personal injury claim, please sign and attach the Medical Release form.
- If your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision Form.

STANDARD TORT CLAIM FORM

General Liability Claim Form

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against Port of Friday Harbor. Some of the information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure. Standard Tort Claim forms cannot be submitted electronically (via e-mail or fax).

PLEASE TYPE OR PRINT IN INK

**Mail or deliver
original claim to**

Port of Friday Harbor
Attn: Phyllis Johnson
PO Box 889
204 Front Street
Friday Harbor, WA 98250

For Official Use Only

No.

Business Hours: Mon. - Fri. 8:00 a.m. – 5:00 p.m.
Closed on weekends and official state holidays.

CLAIMANT INFORMATION

1. Claimant's 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: _____ ☐ a.m. ☐ p.m. (check one)
(mm/dd/yyyy)
8. If the incident occurred over a period of time, date of first and last occurrences:
from _____ Time: _____ ☐ a.m. ☐ p.m. (check one) to _____, Time: _____ ☐ a.m. ☐ p.m. (check one)
(mm/dd/yyyy) (mm/dd/yyyy)
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. Agency or department alleged responsible for damage/injury:

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

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

14. Names, addresses and telephone numbers 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 the cause of the injury or damages. Explain the extent of property loss or medical, physical or mental injuries. 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 Port of Friday Harbor 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 penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signature of Claimant

August 2025

Date and place (city, county, and state)

Authorization for Release of Protected Health Information (PHI) to Port of Friday Harbor

Name: _____
(Last, First, Middle Initial or Middle Name)

Date of Birth: Month _____ Day _____ Year _____

I hereby authorize disclosure of my protected health information to the Port of Friday Harbor for purposes of processing my claim for damages filed with the Port of Friday Harbor.

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, 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 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 and not protected for purposes of evaluating and investigating the claim I have filed with the Port of Friday Harbor's office.

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 the Port of Friday Harbor's Office in writing, and the revocation will be effective as of the date the Port receives it. 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 the Port of Friday Harbor.

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

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:

Port of Friday Harbor
Attn: Phyllis Johnson
PO Box 889
Friday Harbor, WA 98250

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 \$					
	WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.											
OTHER NON-VEHICLE DAMAGE	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.

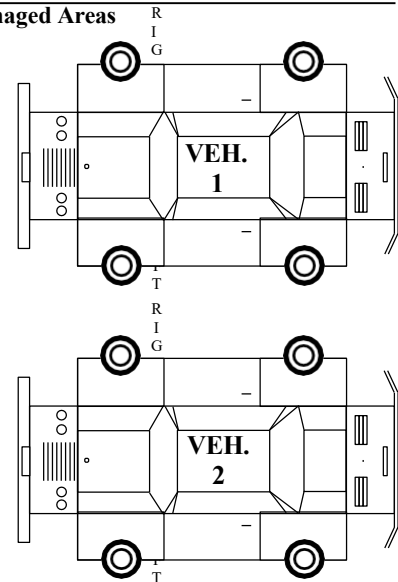
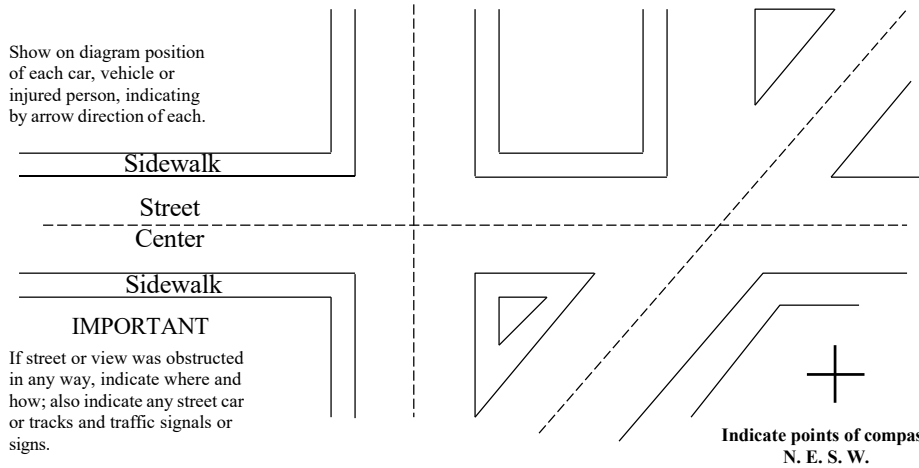
- ☐ Straight Road
☐ Curve – R or L
☐ Level

- ☐ Hillcrest
☐ Uphill
☐ Downhill

- ☐ One Lane
☐ One and One-Half Lane
☐ Two Lane or Four Lane

Mark Damaged Areas

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			
	<input type="checkbox"/> 8 <input type="checkbox"/> NO TRAFFIC CONTROL	<input type="checkbox"/> 2 <input type="checkbox"/> DIVIDED			
	<input type="checkbox"/> 9 <input type="checkbox"/> OTHER	<input type="checkbox"/> 3 <input type="checkbox"/> UNDIVIDED			
NAME OF INVESTIGATING POLICE AGENCY:					
INVESTIGATING AGENCY REPORT NO.					

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 (city, county, and state)