Port of Vancouver USA

Presenting Standard Tort Claims to the Port of Vancouver

Chapter 4.96 RCW requires the Port of Vancouver to receive and process citizen's standard tort claims against Port of Vancouver. Port of Vancouver objectively determines the state's liability for claimed injuries. It fairly compensates claimants for damages when liability is supported, and denies claims when liability is unsupported. Port of Vancouver recognizes its stewardship role in protecting port district resources by striving for efficient and timely service to citizens presenting a Standard Tort Claim to us.

How to present a standard tort claim

1. **Complete the standard tort claim form.**
2. **Present the completed form in person or mail it to Port of Vancouver USA.**

   Port of Vancouver USA
   Port Auditor: Scott Goodrich
   3103 NW Lower River Road
   Vancouver, WA 98660

   Port of Vancouver acknowledges receipt of a Standard Tort Claim by letter to the Claimant. For claim follow-up or acknowledgement questions, call 360-693-3611**.** Business hours: Monday - Friday 8:00 a.m. to 5:00 p.m. The Port of Vancouver office is closed on weekends and official state holidays.

Important items to note when completing the form

- Type or print clearly in ink and sign the 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.
- State law requires an original signature on the Standard Tort Claim form. This means Standard Tort Claim forms cannot be submitted electronically (fax or e-mail).
- The Standard Tort Claim form must be signed by the Claimant; or by a person holding a written power of attorney from the Claimant; or by the attorney in fact for the Claimant; or by an attorney admitted to practice in Washington state on the Claimant's behalf; or by a court-approved guardian ad litem on behalf of the Claimant.
- 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.

For Official Use Only
No.

STANDARD TORT CLAIM FORM
General Liability Claim Form

Pursuant to Chapter 4 RCW, this form is for filing a tort claim against the Port of Vancouver. Some of the information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure. Pursuant to the new law, 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 Vancouver USA
Attn: Scott Goodrich - Port Auditor
3103 Lower River Road
Vancouver, WA 98660

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

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

13. Names, addresses and telephone numbers of all individuals not already identified in #11 and #12 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.

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?

16. Names, addresses 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 the Port of Vancouver in the sum of $_____.

The 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	***Date and place (residential address, city and county)***

Claim #_____

Authorization for Release of Protected Health Information (PHI)
To
The Port of Vancouver

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 Vancouver ("POV"), for purposes of processing my claim for damages filed with the POV.

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

Completed 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, assessment, 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 prescription 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 POV and not protected for purposes of evaluating and investigating the claim I have filed with the POV

_____ Initials — I understand that the specific information to be disclosed in my medical record may 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 POV in writing, and that the revocation will be effective as of the date POV 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 POV.

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

Signature of Authorizing Individual:

_____

Date of Signature:_____

Telephone number:_____

Witness (where patient is over 13 and signing this 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 Vancouver USA
Attn: Scott Goodrich - Port Auditor
3103 Lower River Road
Vancouver, WA 98660