

**STANDARD CLAIM FORM
PLEASE TYPE OR PRINT IN INK**

Please return to:

Steven Taylor
21971 N. Hwy 101 Shelton, WA
98584

Business Hours: 8:00am - 5:00pm

PERSONAL INFORMATION

1. CLAIMANT'S NAME:

| | | | |
|-----------|-------|--------|----------------------------|
| Last Name | First | Middle | Date of Birth (mth/day/yr) |
|-----------|-------|--------|----------------------------|

2. RESIDENCE ADDRESS CURRENT ADDRESS:

3. MAILING ADDRESS (IF DIFFERENT):

4. RESIDENTIAL ADDRESS AT TIME OF INCIDENT:

5. CLAIMANT'S DAYTIME TELEPHONE: () _____ () _____
Home Business

6. CLAIMANT'S E-MAIL ADDRESS _____

INCIDENT INFORMATION

7. DATE OF INCIDENT: _____ / _____ / _____
month day year

8. TIME: _____ A.M. / P.M. (CIRCLE ONE)

9. IF THE INCIDENT OCCURRED OVER A PERIOD OF TIME PLEASE PROVIDED:

BEGINNING TIME : _____ / _____ / _____
month day year

ENDING TIME : _____ / _____ / _____
month day year

10. LOCATION OF INCIDENT:

| | | |
|--------------------------|------|--------|
| Address/Street/Mile Post | city | county |
|--------------------------|------|--------|

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

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

13. LIST ANY OTHER PERSONS WHO HAVE KNOWLEDGE OF THE INCIDENT NOT LISTED IN 11 AND 12 ABOVE.

14. DISTRICT EMPLOYEE ALLEGED RESPONSIBLE FOR DAMAGES/INJURY: _____

15. DESCRIBE CONDUCT AND CIRCUMSTANCES CAUSING INJURY OR DAMAGES, EXPLAINING EXTENT OF MEDICAL, PHYSICAL, OR MENTAL INJURIES (ATTACH ADDITIONAL SHEETS, IF NECESSARY):

16. LAW ENFORCEMENT/SECURITY/FIRE/EMERGENCY AGENCIES WHO RESPONDED TO THE INCIDENT (PLEASE INCLUDE REPORT OR CASE NUMBER IF AVAILABLE)

17. NAME, ADDRESS, AND TELEPHONE NUMBER OF TREATING PHYSICIAN(S) AND ATTACH COPIES OF MEDICAL REPORTS AND BILLINGS:

18. PLEASE PROVIDE COPIES OF ANY DOCUMENTS, PICTURES, OR OTHER RECORDS THAT SUPPORT OR RELATE TO YOUR CLAIM.

19. I / WE DO HEREBY CLAIM DAMAGES FROM _____ IN THE SUM OF \$ _____.

This claim form must be signed either:

- (i) By the claimant, verifying the claim;
- (ii) Pursuant to a written power of attorney, by the attorney in fact for the claimant;
- (iii) By an attorney admitted to practice in Washington state on the claimant's behalf; or
- (iv) By a court-approved guardian or guardian ad litem on behalf of the claimant.

I certify or 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 (address, city and county)