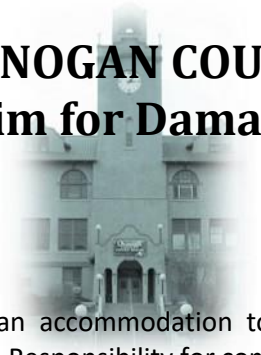
OKANOGAN COUNTY
Claim for Damages



This Claim Form is provided solely as an accommodation to claimants, and the County makes no representations as to its legal sufficiency. Responsibility for complying with all requirements of State law regarding claims rests with the claimant. No County Employee is authorized to advise a claimant in completing this form or reviewing its sufficiency. The County expressly disclaims responsibility for any such advice or review. (If more space is needed to answer any items, attach additional sheets and specify the item number.) **Pursuant to RCW 42.56 any documents submitted with this claim form are public records subject to disclosure.** Send completed original and notarized claim to:

HR Director/Risk Manager
Grainger Building
123 5th Ave North, Room 150
Okanogan, WA 98840

Office Hours: M-F 8:00 a.m. – 5:00 p.m.
Phone: (509) 422-7104

STATE OF WASHINGTON)
) ss.
COUNTY OF OKANOGAN)

I, _____, _____
First Name *Middle* *Last* *Date of Birth*

first duly sworn on oath, depose and say that I am the Claimant herein and believe the contents of this claim to be true. I hereby present a claim for damages against Okanogan County, Washington, based upon the following information as required by RCW 36.45.020: *(please complete items 1 through 17)*

(1) My actual residence at the time of presenting and filing this claim is: _____

_____

(2) My actual residence during the six (6) months immediately prior to the time this claim accrued was: _____

(3) My current mailing address is: _____

(4) My contact phone numbers are: (work) _____ (home) _____ (cell) _____

(5) The incident for which I make claim against the County occurred on the _____ day of _____ at _____ a.m./p.m.

(6) The incident causing damage or injury occurred at the following location (be specific):

(7) My injury or damages were caused or happened as follows:

(8) The nature of the injuries or damages I sustained are (please give full extent of injuries or damages claimed):

(9) Okanogan County is involved because (please identify employees and/or departments involved, including any conversations you had with County personnel during or after the occurrence, including the date, time, place and name of the employee for each conversation):

(10) The names, telephone numbers, and addresses of witnesses to my injury and/or damage are:

Witness #1	Witness #2	Witness #3
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(11) The amount of my claim is $_____. (**A billing** or two **(2) estimates** of the cost of repair **MUST be attached** to this claim.)

(12) I have received insurance payments: ☐ Yes ☐ No My insurance coverage is provided through:

_____

(13) If you are claiming personal injury, have your injuries been treated by a health care provider? ___. If yes, please **attach copies of <u>all</u> billings** for hospitalization and treatment. **Attach a written opinion from your health care provider** describing your injuries, any disability resulting from your injuries, and the course of future treatment. If you are presenting a personal injury claim, please also submit the Medical Release form.

(14) If you were injured, are you Medicare eligible? ☐ Yes Medicare # _____ ☐ No

(15) DATED this _____ day of _____, 20_____.

(16) _____
CLAIMANT

(17) SUBSCRIBED and SWORN to me before this _____ day of _____ 20 _____.

_____
NOTARY PUBLIC

Residing at: _____
(City) (State)

My appointment expires: _____