EXHIBIT A

SKAGIT COUNTY PUBLIC HOSPITAL DISTRICT NO. 1, SKAGIT COUNTY, WASHINGTON TORT CLAIM FORM

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against Skagit County Public Hospital District No. 1, Skagit County, Washington, d/b/a Skagit Regional Health, Skagit Regional Clinics, Skagit Valley Hospital, Cascade Valley Hospital and Cascade-Skagit Health Alliance (the "District"). Some of the information requested on this form is required by RCW 4.96.020 and is subject to public disclosure pursuant to RCW 42.56.

For Official Use Only

PLEASE TYPE OR PRINT CLEARLY IN INK

Mail or deliver original claim to

Regional Director, Risk and Compliance

Attn: Lisa Norton

Skagit County Public Hospital District No. 1,

d/b/a Skagit Regional Health 1515 North 18th Street

Mount Vernon, Washington 98273

Business Hours: Monday – Friday 8:30 a.m. – 5:00 p.m. Closed on weekends and official state holidays.

Ί.	Claimant's name:					
		Last name	First	Middle	Date of birth	
(mn	n/dd/yyyy)					
2.	Inmate DOC num	ber (if applicable):				
3.	Current residentia	al address:				
4.	Mailing address (if different):				
Residential address at the time of the incident:					_	
	(if different from o	current address)				
6.	Claimant's daytim	ne telephone number:				
		I	Home		Business or Cell	
7	Claimant's e-mail	address.				

8.	Date of the incident:(mm/dd/yyyy)	Time: a	a.m. p.m. (check one)
9.	If the incident occurred over a period of	time, date of first and last o	occurrences:
	from(mm/dd/yyyy)	Time:(mm/dd/yyyy)	☐ a.m. ☐ p.m.
	to (mm/dd/yyyy)	Time:(mm/dd/yyyy)	☐ a.m. ☐ p.m.
10.	Location of incident:State and county	City, if applicable	e Place where occurred
11.	If the incident occurred on a street or hig	ghway:	
	Name of street or highway	Milepost number	At the intersection with or nearest intersecting street
12.	District department you believe is respons	nsible for damage/injury:	
13.	Names and telephone numbers of all pe	rsons involved in or witnes	s to this incident:
	Names and telephone numbers of all Dident:	strict employees having kno	owledge about this
15.	Names and telephone numbers of all inc that have knowledge regarding the liabil Claimant's resulting damages. Please in of each person's knowledge. Attach add	ity issues involved in this in nclude a brief description a	ncident, or knowledge of the s to the nature and extent

were	Describe how the District caused your injuries or damages (if your injuries or damages e not caused by the District, do not use this form. You must file your claim against the rect entity). Explain the extent of property loss or medical, physical or mental injuries. Attach itional 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. Submit copies of all medical reports and billings.
19.	Please attach documents which support the allegations of the claim.
20.	I claim damages from the District in the sum of \$
This	Claim form must be signed by one of the following (check appropriate box).
	Claimant
	Person holding a written power of attorney from the Claimant
	Attorney in fact for the Claimant
	Attorney admitted to practice in Washington State on the Claimant's behalf
	Court-approved guardian or guardian ad litem on behalf of the Claimant

I declare under penalty of perjury under the true and correct.	e laws of the state of Washington that the foregoing is
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)