



8. Date of the incident: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m. (check one)  
(mm/dd/yyyy)

9. If the incident occurred over a period of time, date of first and last occurrences:

from \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
(mm/dd/yyyy) (mm/dd/yyyy)

to \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
(mm/dd/yyyy) (mm/dd/yyyy)

10. Location of incident: \_\_\_\_\_  
State and county City, if applicable Place where occurred

11. If the incident occurred on a street or highway:

Name of street or highway	Milepost number	At the intersection with or nearest intersecting street
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12. District department you believe is responsible for damage/injury:

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. Names and telephone numbers of all District employees having knowledge about this incident:

\_\_\_\_\_

\_\_\_\_\_

15. Names and telephone numbers of all individuals not already identified in #13 and #14 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.

\_\_\_\_\_

\_\_\_\_\_

16. Describe how the District caused your injuries or damages (**if your injuries or damages were not caused by the District, do not use this form. You must file your claim against the correct entity**). Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.

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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.

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18. Names, addresses and telephone numbers of treating medical providers. Submit copies of all medical reports and billings.

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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 laws of the state of Washington that the foregoing is true and correct.

\_\_\_\_\_  
***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)***