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.

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.

1. Claimant’s name: ________________________________  
   Last name First Middle Date of birth ____________________  
   (mm/dd/yyyy)

2. Inmate DOC number (if applicable): ________________________________

3. Current residential address: ______________________________________

4. Mailing address (if different): _____________________________________

5. Residential address at the time of the incident: _______________________
   (if different from current address)

6. Claimant’s daytime telephone number: _____________________________  
   Home Business or Cell

7. Claimant’s e-mail address: ________________________________________
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)

    to ________________ Time: __________  □ a.m. □ p.m.  
    (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

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.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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 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)