



Snohomish County

CLAIM FOR DAMAGE FORM

For Official Use Only

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against Snohomish County. Some of the information requested on this form is required by RCW 4.96.020. The contents of this form and all attached materials may be subject to public disclosure.

PLEASE TYPE OR PRINT IN INK.

Mail or deliver original claim to: **Snohomish County Risk Manager**
3000 Rockefeller Avenue, M/S 610
Everett, WA 98201-4046

Hours: Monday – Friday, 8:00 a.m. to 5:00 p.m.
(Excluding Weekends and Holidays)

CLAIMANT INFORMATION

(1) Claimant's name: _____
(Last Name) (First Name) (MI) Date of Birth (MM/DD/YYYY)

(2) Current residential address: _____

(3) Mailing address (if different): _____

(4) Residential address on the date of the incident (if different from current address):

(5) Claimant's daytime phone numbers: Home Phone # _____
Business or Cell # _____

E-mail address: _____

(6) Are you represented by an attorney for this claim? NO YES (If yes, provide details.)

Name of Attorney: _____

Address of Attorney: _____

Phone number of Attorney: _____

(14) Names, addresses and telephone numbers of all persons involved in or witness to this incident:

(15) Names of all Snohomish County employees having knowledge of this incident:

(16) Names, addresses, 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.

(17) Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom? Attach a copy of any reports. (Please note that all attachments may be subject to public disclosure.)

(18) Names, addresses and telephone numbers of treating medical providers. Attach copies of all medical reports and billings. (Please note that all attachments may be subject to public disclosure.)

****ADDITIONAL INFORMATION REQUIRED FOR AUTOMOBILE CLAIMS ONLY****

License Plate#: _____ Driver License #: _____

Type of Auto: _____
(Year) (Make) (Model)

DRIVER: _____ **OWNER:** _____

Address: _____

Address: _____

This claim form must be signed by the Claimant, a person holding a written Power of Attorney from the Claimant, the Attorney in Fact for the Claimant, an Attorney admitted to practice in the State of Washington on the Claimant's behalf or by a Court-Approved Guardian or Guardian Ad Litem on behalf of the Claimant.

NOTE: THIS FORM MUST BE SIGNED

I, the undersigned, declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

X _____
Signature of Claimant

Date: _____

X _____
Printed Name

X _____
Signature of Claimant

Date: _____

X _____
Printed Name

(Add additional signature blocks as necessary)