

**Sedro-Woolley School District #101
TORT CLAIM FORM
RCW 4.96.020**

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against the Sedro-Woolley School District ("District"). Information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure. Any person wishing to file a tort claim with the District should fill this form out accurately and completely and present the form in person or by mail to the Superintendent of the Sedro-Woolley School District at the address given below between the weekday business hours of 8am and 4pm.

Present to the Superintendent at: <i>801 Trail Rd. Sedro-Woolley</i>	For School District Use Only: Date Received:
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CLAIMANT INFORMATION

1. **Claimant's Name:** _____

2. **Claimant's Date of Birth:** _____

3. **Claimant's Current Residential Address:**

4. **Claimant's Mailing Address (if different):**

5. **Claimant's Residential Address at the Time of the Incident (if different from current address):**

6. **Claimant's Daytime Phone Number:** _____

7. **Claimant's E-Mail Address:** _____

INCIDENT INFORMATION

8. State the amount of damages claimed against the District as a result of the incident.

\$ _____

9. Date of the incident: _____

Time: _____ **a.m./p.m.** (*circle one*)

10. Location of incident: _____

11. Names, addresses and telephone numbers of all persons involved in this incident or who were witnesses to this incident:

(List additional names of witnesses and their contact information, if any, on a separate page and attach to this page.)

12. Names, addresses and telephone numbers of all District employees having knowledge about this incident:

(List additional names of District employees and their contact information, if any, on a separate page and attach to this page.)

13. Describe the injury or damage which resulted from the incident.

(List additional information, if any, on a separate page and attach to this page.)

14. **What is the basis for making this claim against the District? Please provide specific details regarding the conduct and circumstances that you believe the District or its employees engaged in that caused your injury or damage. (Such information can also be provided on separate pages attached to this page.)**

Attorney

15. **Attorney's contact information if you are represented in this matter by an attorney:**

Name: _____

Phone: _____

Email: _____

Address: _____

Signature and Verification

16. This Claim form must be signed by the Claimant, a person holding a written power of attorney from the Claimant, by the attorney in fact for the Claimant, by an attorney admitted to practice in Washington State on the Claimant's behalf, or by a court-approved guardian or guardian ad litem on behalf of the Claimant.

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

DATED: _____, _____ **at** _____, **Washington.**

Signature (actual, non-electronic signature required)

Print the Name of the Person Signing