Mount Vernon School District No. 320
TORT CLAIM FORM
RCW 4.96.020

INSTRUCTIONS FOR COMPLETING A STANDARD TORT CLAIM FORM

1. Complete the Standard Tort Claim Form attached:

    - **Agent to receive claim:** Dr. Ismael Vivanco, Superintendent of Schools
    - **Office location:** 124 East Lawrence Street, Mount Vernon, WA 98273
    - **Mailing address:** (same as above)
    - **Business Hours:** Monday – Friday, 8:00 a.m.-5:00 p.m. (closed on weekends and official school holidays)

2. Tort Claim Form must be typed or printed clearly in ink.

3. Provide all requested information and any available documents supporting your claim.

4. If the requested information cannot be supplied in the space provided, please use additional blank sheets so your claim can be easily read and understood.

5. Signed by an authorized party.

6. Present properly completed and signed Tort Claim Form in one of the following manners:

    - Personal delivery to the registered agent or authorized person in the office during above business hours.
    - Deliver by registered mail to the registered agent.
    - Deliver by certified mail (with return receipt) to the registered agent.

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Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against the Mount Vernon 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's Office** of the Mount Vernon School District at the address given below between the weekday business hours of 8:00 am and 5:00 pm.

Mail or deliver original claim to:	*For School District Use Only:*
Ismael Vivanco, Superintendent Mount Vernon School District No. 320 124 East Lawrence Street Mount Vernon, WA 98273	Date Received:

CLAIMANT INFORMATION

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

2. **Claimant's Date of Birth (mm/dd/yyyy):** _____

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:** _____ _____
   Home **Business or Cell**

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)***
(mm/dd/yyyy)

10. Location of incident: _____

11. If the incident occurred on a roadway:

_____
Name of street/highway Cross streets

12. 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.)

13. 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.)

14. Describe the injury or damage which resulted from the incident. Explain the extent of property loss or medical, physical or mental injuries.

_____

_____

_____

_____

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

15. 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

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

Name: _____

Phone: _____

Email: _____

Address: _____

_____

17. Please attach documents which support the allegations of the claim.

Signature and Verification

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 of Claimant *(actual, non-electronic signature required)*

OR

_____

Signature of Representative *(actual, non-electronic signature required)*

_____

Print the Name of the Person Signing