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SAMARITAN HEALTHCARE

Recording Requested By and Return To:
Kurt Kuykendall
Director of Quality & Risk Management
Samaritan Healthcare
801 East Wheeler Road
Moses Lake, WA 98837

PUBLIC HOSPITAL DISTRICT NO. 1,
GRANT COUNTY, WASHINGTON

RESOLUTION NO. 12/23-02

A RESOLUTION OF THE BOARD OF COMMISSIONERS OF PUBLIC HOSPITAL DISTRICT NO. 1, GRANT COUNTY, WASHINGTON, APPOINTING AN AGENT FOR SERVICE OF CLAIMS AND ADOPTING A UNIFORM CLAIM FORM PURSUANT TO RCW 4.96.020.

WHEREAS, Public Hospital District No. 1, Grant County, Washington, d/b/a Samaritan Healthcare (the "District"), is a "local governmental entity" as that term is defined in Chapter 4.96 RCW; and

WHEREAS, the Board of Commissioners of the District (the "Commission") is required by RCW 4.96.020 to appoint an agent to receive any claim for damages made under chapter 4.96 RCW and to identify the agent and the address where the agent may be reached during the normal business hours of the District and to record notice thereof with the county auditor in which the District is located; and

WHEREAS, pursuant to Resolution No. 05/15-01, the Commission appointed Becky DeMers as the District's agent to receive any claim for damages made under chapter 4.96 RCW; and

WHEREAS, the Commission desires to appoint a new agent to receive any claim for damages made under chapter 4.96 RCW

WHEREAS, RCW 4.96.020 requires the District to provide a standard tort claim form for use by claimants; and

WHEREAS, the Commission desires to approve the claim form in compliance with RCW 4.96.020;

NOW, THEREFORE, BE IT RESOLVED by the Board of Commissioners of Grant County Public Hospital District No. 1 as follows:

1. The Director of Quality & Risk Management, which position is currently held by Kurt Kuykendall, is hereby authorized to accept on behalf of the District tort claim forms submitted to the District pursuant to RCW 4.96.020 during all non-holiday weekdays from 8:30 a.m. until 5:00 p.m. at 801 East Wheeler Road, Moses Lake, Washington, 98837.

2. The tort claim form attached as Exhibit A hereto is adopted and designated as the District's tort claim form pursuant to RCW 4.96.020.

3. The District's executive team and legal counsel are hereby authorized to take all actions consistent herewith and to record this resolution, with Exhibit A attached thereto, with the Grant County Auditor.

4. The appointment of Becky DeMers as the District's agent to receive any claim for damages made under chapter 4.96 RCW is hereby repealed.

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ADOPTED BY VOTE OF THE BOARD OF COMMISSIONERS OF PUBLIC HOSPITAL DISTRICT NO. 1, GRANT COUNTY, WASHINGTON, AT A REGULAR OPEN PUBLIC MEETING THEREOF, THIS 12TH DAY OF DECEMBER, 2023.

President

Secretary

Commissioner

Commissioner

Commissioner

GRANT COUNTY PHD NO. 1 RESOLUTION NO. 12/23-02
APPOINTING AGENT FOR SERVICE
PURSUANT TO RCW 4.96.020
FG: 102257809.1

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INSTRUCTIONS FOR COMPLETING THE STANDARD TORT CLAIM FORM

Pursuant to RCW 4.96.020, these instructions are for filing a Tort Claim Form against Public Hospital District No. 1 of Grant County d/b/a Samaritan Healthcare (the "District").

Before filing a Tort Claim against the District, please read the following instructions:

- TYPE OR PRINT CLEARLY IN INK.
- Provide all requested information and any available documents or evidence supporting your claim, such as medical records or bills for personal injuries.
- If the requested information cannot be supplied in the space provided, please use additional blank sheets.
- The following are examples on how to complete the Standard Tort Claim Form:

1. Smith, Jane Doe, 01/01/1234
2. 1234 E. Eden Road, Moses Lake, WA 98837
3. P.O. Box 0000, Moses Lake, WA 98837
4. Same
5. 509/123-4567
6. Janedoesmith@email.com
7. January 1, 1990, 12:00 p.m.
8. If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item 7.
9. Grant County, WA, Wheeler Road
10. Wheeler Road
11. Jane Doe Smith, 1234 E. Eden Road, Moses Lake, WA 98837, 509/123-4567
12. List all District employees having knowledge of the incident in question.
13. List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items 12 and 13. Also include a description of their knowledge.
14. Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why. In addition, please explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.
15. If you reported this incident to law enforcement or any hospital staff or employees, please provide a copy of the report or contact information to the person(s) you spoke with.

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16. Please provide all of your medical providers with their names, address, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include your medical records and bills.
17. Please attach documents which support the claim allegations.
18. Please provide the dollar amount for your damages, including your time loss, medical costs, property damage loss, etc. This amount should represent your opinion of total compensation.
19. Please sign the form, and also put the date you signed the form and where you signed the form

ONCE THIS FORM IS COMPLETED, PRESENT IT TO THE AGENT OF RECORD FOR THE DISTRICT. THE IDENTITY AND CONTACT INFORMATION OF THE AGENT OF RECORD IS ON FILE AT THE OFFICE OF THE GRANT COUNTY AUDITOR, AND IS ALSO PROVIDED IN THE TORT CLAIM PACKET.

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STANDARD TORT CLAIM FORM

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against Public Hospital District No. 1, Grant County, Washington, d/b/a Samaritan Healthcare (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 Tort Claim Form to

Kurt Kuykendall, Director of Quality & Risk Management
Public Hospital District No. 1 of Grant County
801 East Wheeler Road
Moses Lake, WA, 98837

Business Hours: Monday – Friday 8:00 a.m. – 5:00 p.m.
Closed weekends and holidays.

1. Claimant's name:_____
Last name First Middle Date of birth

2. Current residential address:_____

3. Mailing address (if different):_____

4. Residential address at the time of the incident:_____
(if different from current address)

5. Claimant's daytime telephone number:_____ _____
Home Business/Cell

6. Claimant's e-mail address:_____

7. Date of the incident:_____ Time: ☐ a.m. ☐ p.m. (check one)
(mm/dd/yyyy)

8. 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)

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9. Location of incident: _____

State and County City, if applicable Place where occurred

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

_____

Name of street or highway Milepost number At the intersection with or nearest intersecting street

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

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

13. Names, addresses and telephone numbers of all individuals not already identified in #11 and #12 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):

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14. Describe the cause of the injury or damages. Explain the extent of property loss or medical, physical or mental injuries (Attach additional sheets if necessary):

15. State whether this incident has been reported to law enforcement, or any District employee (If so, when and to whom? Please attach a copy of the report or contact information):

16. Names, addresses and telephone numbers of treating medical providers (Attach copies of all medical reports and billings):

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

18. I claim damages from the District in the sum of $_____.

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This Standard Tort Claim Form must be completed and 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 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)***

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