

**STANDARD CLAIM FORM
PLEASE TYPE OR PRINT IN INK**

Please return to:
Skagit Transit
600 County Shop Lane
Burlington, WA 98233
Business Hours: 9:00am - 5:00pm

PERSONAL INFORMATION

1. CLAIMANT'S NAME:

Last Name	First	Middle	Date of Birth (mth/day/yr)
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2. RESIDENCE ADDRESS (at time of incident):

3. MAILING ADDRESS (IF DIFFERENT):

4. CLAIMANT'S DAYTIME TELEPHONE: () _____ () _____
Home Business

INCIDENT INFORMATION

5. DATE OF INCIDENT: _____ / _____ / _____
month day year

6. TIME: _____ A.M. / P.M. (CIRCLE ONE)

7. LOCATION OF INCIDENT:

address	city	county
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8. NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ALL PERSONS INVOLVED, OR WITNESS, TO THIS INCIDENT:

9. NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ALL TRANSIT MEMBER EMPLOYEES HAVING KNOWLEDGE ABOUT THIS INCIDENT:

10. TRANSIT AGENCY ALLEGED RESPONSIBLE FOR DAMAGES/INJURY: _____

11. DESCRIBE CONDUCT AND CIRCUMSTANCES CAUSING INJURY OR DAMAGES, EXPLAINING EXTENT OF MEDICAL, PHYSICAL, OR MENTAL INJURIES (ATTACH ADDITIONAL SHEETS, IF NECESSARY):

12. NAME, ADDRESS, AND TELEPHONE NUMBER OF TREATING PHYSICIAN(S) AND ATTACH COPIES OF MEDICAL REPORTS AND BILLINGS:

13. I / WE DO HEREBY CLAIM DAMAGES FROM _____ IN THE SUM OF \$ _____.

CLAIMANT OR LEGAL GUARDIAN MUST SIGN THIS CLAIM FORM

I certify or 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 (address, city and county)

If the claimant is incapacitated from verifying, presenting, and filing the claim or if the claimant is a minor, or is a nonresident of this state, the claim may be verified, presented, and filed on behalf of the claimant by any relative, attorney, or agent representing the claimant. All claims for the damages against Washington State Transit Insurance Pool Members arising out of tortious conduct shall be presented to and filed with the appropriate transit property.