STANDARD CLAIM FORM
PLEASE TYPE OR PRINT IN INK

PERSONAL INFORMATION

1. CLAIMANT'S NAME:

________________________________________________________________
Last Name             First              Middle                 Date of Birth (mth/day/yr)
________________________________________________________________

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

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:

________________________________________________________________
________________________________________________________________
________________________________________________________________

Please return to:
Skagit Transit
600 County Shop Lane
Burlington, WA 98233
Business Hours: 9:00am - 5:00pm
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 tortuous conduct shall be presented to and filed with the appropriate transit property.