

**STANDARD TORT CLAIM FORM**  
**General Liability Claim Form, Grant County, Washington**

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against Grant County, Washington. Information requested on this form is required by RCW 4.92.100 and may be subject to public disclosure. Claim forms cannot be submitted electronically (via e-mail or facsimile).

**PLEASE TYPE OR PRINT IN INK**

**Mail or deliver original claim to:**

Grant County Auditor  
PO Box 37  
Ephrata, WA 98823

Physical Address:  
35 C Street  
(2<sup>nd</sup> Floor, old Courthouse)

**Business Hours:** Monday-Friday, 8:00 a.m. to 5:00 p.m.  
Closed on weekends, official state holidays, and 1 floating holiday (late December).

**CLAIMANT INFORMATION**

1. Claimant's Name:

\_\_\_\_\_

Last Name	First	Middle	Date of birth (mm/dd/yyyy)
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2. Current residential address:

\_\_\_\_\_

3. Current mailing address (if different):

\_\_\_\_\_

4. Residential address for six months prior to the date of the incident (if different from current address):

\_\_\_\_\_

5. Claimant's daytime telephone number: \_\_\_\_\_

Home	Business
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6. Claimant's e-mail address: \_\_\_\_\_

**INCIDENT INFORMATION**

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** \_\_\_\_\_  
(mm/dd/yyyy)  
Time: \_\_\_\_\_ a.m. \_\_\_\_\_ p.m. (check one) **To** \_\_\_\_\_  
(mm/dd/yyyy)  
Time: \_\_\_\_\_ a.m. \_\_\_\_\_ p.m. (check one)

9. Location of incident:

\_\_\_\_\_

State and County	City, if applicable	Place where occurred
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**INCIDENT INFORMATION (Cont'd)**

**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.** Grant County agency or department alleged responsible for damage/injury:

\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**13.** Names, addresses, and telephone numbers of all Grant County employees having knowledge about this incident:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**15.** 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**16.** Has the incident been reported to law enforcement, safety, or security personnel? If so, when and to whom?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INCIDENT INFORMATION (Cont'd)**

17. Names, addresses, and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

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18. Please attach documents which support the claim's allegations.

19. I claim damages from Grant County in the sum of \$\_\_\_\_\_.

**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 or 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)**