CHELAN COUNTY CLAIM FOR DAMAGES FORM

CLAIM NO. 2015-_____ DATE RECEIVED: _____

Pursuant to Chapter 4.96 RCW, this Claim for Damages form is provided solely as an accommodation to the claimant, and the County makes no representations as to its legal sufficiency. Responsibility for complying with all requirements of State law regarding claims rests with the claimant. No County employee is authorized to advise a claimant in completing this form or reviewing its sufficiency. The County expressly disclaims responsibility for any such advice or review.

Send Original Claim for Damages Form by Regular Mail, Registered Mail, or Certified Mail, Return Receipt Requested, or Deliver in Person to:

CLERK OF THE BOARD
CHELAN COUNTY COMMISSIONERS
400 DOUGLAS STREET, SUITE 201
WENATCHEE, WA 98801
Business Hours: Mon-Thurs 8:00 am – 5:00 pm; Fri 8:00 am - Noon
(Closed Noon – 1:00 pm)

PLEASE TYPE OR PRINT IN INK. If more space is needed to answer any items, attach additional sheets and specify the item number.

CLAIMANT INFORMATION

1) Name: _____
(Print Full Name) (DOB: mm/dd/yyyy)

2) Current Residential Address: _____

3) Mailing Address (if different): _____

4) Residential address ***on the date this incident occurred*** (if different from current address):
_____

5) Daytime phone numbers: _____ _____ _____
(Home) (Work) (Cell)

6) E-Mail Address: _____

INCIDENT INFORMATION

7) The incident for which I make claim against Chelan County occurred on the _____ day of _____, 20_____ at the hour of _____ a.m. /p.m.

8) The incident occurred at the following location:
_____
_____
_____

9) Chelan County departments or employee(s) allegedly responsible for damage/injury: _____

10) Names, addresses, and telephone numbers of all persons involved in, or witness to, this incident: _____

11) My injury or damages were caused or happened as follows: _____

12) Please describe the nature and extent of your injury or damages. _____

13) I claim damages from Chelan County in the sum of $_____

14) The itemized amount of damages I claim are attached to this form. **A billing or two estimates of the cost of repairs must be attached to this claim, together with the name of your insurance agency. If your claim relates to a personal injury, please attach copies of all medical reports and billings.**

15) If you are claiming injury, are you a Medicare beneficiary? ☐ Yes ☐ No (Check One). If Yes, please provide your Medicare number: _____

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 under the laws of the State of Washington, that the foregoing is true and correct.

DATED this ____ day of _____, 20___

_____
Signature of Claimant

_____
Place of Signing (residential address, city, and county)