STANDARD CLAIM FORM

Please return to:

Link Transit

Attention Board Clerk

2700 Euclid Avenue

 Wenatchee, WA 98801

Business Hours: 8:00am - 4:30pm

**PLEASE TYPE OR PRINT IN INK**

PERSONAL INFORMATION

1. CLAIMANT'S NAME:

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

Last Name First Middle Date of Birth (month/day/year)

1. RESIDENCE ADDRESS (at time of incident):

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

1. MAILING ADDRESS (IF DIFFERENT):

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

1. CLAIMANT'S DAYTIME TELEPHONE: ( ) \_\_\_\_\_\_\_\_\_\_\_ ( ) \_\_\_\_\_\_\_\_\_\_\_\_

Home Business

INCIDENT INFORMATION

1. DATE OF INCIDENT: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

 month day year

1. TIME: \_\_\_\_\_\_\_ A.M. / P.M. (CIRCLE ONE)
2. LOCATION OF INCIDENT:

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

address city county

1. NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ALL PERSONS INVOLVED, OR WITNESS, TO THIS INCIDENT:
2. NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ALL TRANSIT MEMBER EMPLOYEES HAVING KNOWLEDGE ABOUT THIS INCIDENT:
3. TRANSIT AGENCY ALLEGED RESPONSIBLE FOR DAMAGES/INJURY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. DESCRIBE CONDUCT AND CIRCUMSTANCES CAUSING INJURY OR DAMAGES, EXPLAINING EXTENT OF MEDICAL, PHYSICAL, OR MENTAL INJURIES (ATTACH ADDITIONAL SHEETS, IF NECESSARY):
5. NAME, ADDRESS, AND TELEPHONE NUMBER OF TREATING PHYSICIAN(S) AND ATTACH COPIES OF MEDICAL REPORTS AND BILLINGS:
6. 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.