Please return to:

Whatcom Transportation Authority
4011 Bakerview Spur
Bellingham, WA 98226
8:00 am – 5:00 pm M-F

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:

_____
_____
_____

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.