Mail or Deliver Original Claim to:

Agent to Receive Claim: Lila Freshment
District: Columbia Irrigation District
Business Hours: 7:30 am - 4:00 pm
Address: 10 E Kennewick Avenue
Kennewick, WA 99336

CLAIM FOR DAMAGE FORM

Under penalty of law, Enduris intends to prosecute all false claims.

CLAIMANT INFORMATION

(1) Claimant's Name: _____,
(Last Name) (First) (Middle) (Date of Birth: mm/dd/yyyy)

(2) Current Residential Address: _____,

(3) 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 Phone Numbers: Home Phone # _____, Business/Cell # _____,
Claimant's Email Address: _____

INCIDENT INFORMATION

(6) Date of Incident: _____ Time: _____ ❑a.m. ❑p.m. (check one)
(mm/dd/yyyy)

(7) If the incident occurred over a period of time, date of first and last occurrences:
From: _____ Time: _____ ❑a.m. ❑p.m. (check one)
(mm/dd/yyyy)
To: _____ Time: _____ ❑a.m. ❑p.m. (check one)
(mm/dd/yyyy)

(8) Location of Incident: _____
(state and county) (city if applicable) (place where occurred)

(9) If the incident occurred on a street or highway: _____
(name of street/highway) (mile post) (at intersection with or nearest intersecting street)

(10) District or agency alleged responsible for damage/injury: _____

(11) Names, address, and telephone numbers of all persons involved in or witness to this incident:

_____

_____

(12) Name, addresses, and telephone numbers of all district or agency employee having knowledge about this incident:

_____

_____

(13) Names, addresses, and telephone numbers of all individuals not already identified in (11) and (12) 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.

_____

_____

(14) 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.

_____

_____

(15) Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom?

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

(17) Please attach documents which support the claim's allegations.

(18) I claim damages in the amount of $_____

(19) If you are injured, are you a Medicare beneficiary? ❑Yes ❑No (check one) If Yes, please complete the Medicare Verification form.

****ADDITIONAL INFORMATION REQUIRED FOR AUTOMOBILE CLAIMS ONLY****

License Plate # _____ Driver License # _____

Type Auto: _____
(year) (make) (model)

DRIVER:
Address: _____

Phone #: _____

OWNER:
Address: _____

Phone #: _____

PASSENGERS:
Name: _____
Address: _____

Name: _____
Address: _____

The claimant must sign this claim form unless he or she is incapacitated, a minor, or a nonresident of the state, in which case it may be signed on behalf of the claimant by any relative, attorney, or agent representing the claimant.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

NOTE: THIS FORM MUST BE SIGNED AND NOTARIZED

I, _____, being first duly sworn, depose and say that I am the claimant for the above described; that I have read the above claim, know the contents thereof and believe the same to be true.

X _____

X _____
Signature of Claimant(s)

Subscribed and sworn to before me this _____day of _____, 20 ____.

_____
NOTARY PUBLIC in and for the State of Washington