SPOKANE COUNTY LIBRARY DISTRICT: CLAIM FOR DAMAGES FORM

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against the Spokane County Library District (District). Some of the information requested on this form is required by RCW 4.92.100 and some or all of this form may be subject to public disclosure pursuant law. Pursuant to the law, this Claim for Damages Form must be delivered in person or when received by the District Executive Director at the address below by regular mail, registered mail, or certified mail, with return receipt requested. This Claim for Damages Form cannot be submitted electronically (via e-mail or fax).

PLEASE TYPE OR PRINT IN BLACK OR BLUE INK

MAIL OR DELIVER ORIGINAL SIGNED CLAIM TO:

(Business hours: Mon-Fri. 8:30 am – 4:30 pm. Closed on weekends and District holidays)

Executive Director
Spokane County Library District
4322 N. Argonne Rd.
Spokane, WA 99212

CLAIMANT INFORMATION:

1. Name:_____

(Last Name, First, Middle, Date of Birth mm/dd/yyyy)

2. Current Residential Address:

_____

a. Mailing address or address at time of incident (if different):

_____

3. Contact Information: Telephone:_____ Email: _____

Incident Information: (Please use additional space on the reverse side of the form or attach additional pages and supportive documents as needed.)

4. Date and Time Occurred:

Date:_____ Time:_____ am ◯ pm ◯

5. Location/Site (to include address/street name). Please be very specific:

_____
_____
_____
_____

6. What Happened? Describe in your own words how any injury or damage occurred and why you believe the District is responsible.

7. Was Your Property Damaged (i.e. Home, Auto, or Personal Property)? Yes ◯ No ◯

If Yes, please fully describe the damaged property, such as age, make model, condition, value, or extent of damage, and the extent of property loss.

8. Were You Injured? Yes ◯ No ◯ If Yes, please attach copies of medical reports and billings and answer the following:

a. Describe in detail Your Medical, Physical, or Mental Injuries:

b. Name and Contact Information of Your Doctor or Health Care Provider:

c. Did you experience Wage Loss: Yes ◯ No ◯ If Yes: Rate of Pay:

Employer Name and Address:

9. Witnesses or those individuals who have knowledge of the claim: Name, Addresses, and Contact Information (Please use additional space on the reverse side of the form or attach additional pages and supportive documents as needed):

a.

b.

10. Has this incident been reported to law enforcement, emergency medical services, or District personnel? If so, when and to whom? Please attach a copy of the report or contact information:

_____

_____

_____

CLAIM:

11. I claim damages from the Spokane County Library District in the sum of:

$ _____

12. Signature: 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.

_____ _____

Claimant Signature Date and place (residential address, city and county)

_____

Print Name of Claimant

Or

_____ _____

Signature of Representative Date and place (residential address, city and county)

_____ _____

Print Name of Representative Bar Number (if applicable)

Form Date: 06/2025