



10. NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ALL COMMUNITY TRANSIT EMPLOYEES HAVING KNOWLEDGE ABOUT THIS INCIDENT: (Attach additional sheets if necessary)

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11. DESCRIBE CONDUCT AND CIRCUMSTANCES CAUSING INJURY OR DAMAGES, EXPLAINING EXTENT OF MEDICAL, PHYSICAL, OR MENTAL INJURIES (ATTACH ADDITIONAL SHEETS, IF NECESSARY):

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12. NAME, ADDRESS, AND TELEPHONE NUMBER OF TREATING PHYSICIAN(S) AND ATTACH COPIES OF MEDICAL REPORTS AND BILLINGS:

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13. I / WE DO HEREBY CLAIM DAMAGES FROM \_\_\_\_\_ IN THE SUM OF \$\_\_\_\_\_.

(To Be Determined (TBD) is appropriate if you do not have a Damage Estimate or have not completed medical treatment.)

**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 tortious conduct shall be presented to and filed with the appropriate transit property.