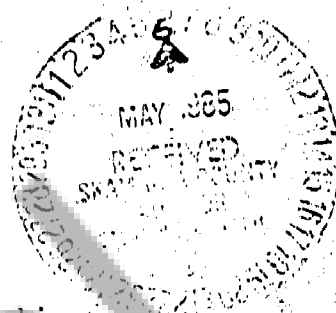


99213



FORM OF CLAIM FOR DAMAGES

TO THE BOARD OF COUNTY COMMISSIONERS of Skamania County, Washington:

PLEASE TAKE NOTICE that in accordance with Chapter 36.45 of the Revised Code of Washington, I Gary M Wendell

hereby present you with my claim for damages against the County of Skamania, State of Washington, with the information required to be given by RCW 36.45.020 as follows:

1. That the injury for which I claim damages against the County of Skamania, State of Washington, occurred on or about the August day of 24, 19 84.

2. That the place of injury was Carson, Wa

3. That the location and description of the defect which caused the injury are

water hose, under pressure, one Co. Truck
blew off, had been glued on + Ray Bliss was
checking it out.

4. That the injury is described as follows:

Started the motor, turned the water on to ck the
hose, I was observing when it blew off.

5. That the amount of damages claimed is as follows: 6000

See enclosed

6. That the actual residence of the claimant at the time of presenting and filing this claim is P.O. B 536 Carson 98610

7. That the actual residence of the claimant for a period of six months immediately prior to the time that this claim accrued was Same

DATED: 5-6-85, 19 85

Gary M Wendell
(Claimant)

5/26/85

MID-COLUMBIA FAMILY HEALTH CENTER

216 ☐ WHITE SALMON OFFICE
☒ STEVENSON OFFICE

P.O. BOX 1519
P.O. BOX 390

WHITE SALMON, WASHINGTON 98672
STEVENSON, WASHINGTON 98648

493-2133
427-4212

Gary Wendell
Box 536
Carson, WA 98610

7-24-84
DOB 7-1-46
427-8352

- ☐ MARK E. DEUTCHMAN, M.D.
☐ WILLIAM R. GILLANDERS, M.D.
☐ JAMES G. JANNEY, M.D.
☐ SAMUEL D. MOON, M.D.
☒ RAYMOND FITZSIMMONS, M.D.
☐ GREGORY D. ZUCK, M.D.
☐ CYNTHIA K. JANNEY, P.A.
☐ OTHER

SKA Co Accident

SS# 368-4-2268

3:30 PM TRS #91-1152824

AUTHORIZATION TO RELEASE INFORMATION
I HEREBY AUTHORIZE MID-COLUMBIA FAMILY HEALTH CENTER AND THE ABOVE NAMED
PHYSICIAN TO RELEASE TO THE INSURANCE COMPANY ABOVE ANY INFORMATION
ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT (IF THE PATIENT IS
MINOR, SIGN BY PARENT OR GUARDIAN)

ASSIGNMENT OF INSURANCE BENEFITS
I HEREBY AGREE TO FULL RESPONSIBILITY FOR ALL EXPENSES INCURRED BY OR ON
ACCOUNT OF THIS PATIENT AND HEREBY ASSIGN ANY AND ALL INSURANCE BENEFITS DUE
TO ME TO THE FULL EXTENT OF MY FINANCIAL OBLIGATION TO SAID CLINIC

SIGNED INSURED PERSON X

SERVICE	NEW	ESTABL	CHARGE	SERVICE	CHARGE	DIAGNOSIS FOR INSURANCE	DX - ICD-9 CODE	ICDA	HO	HULL OUT
OFFICE				SURGERY				DIAGNOSIS		
O.V. MINIMAL (5)		1	90030	47 SURGERY F/U		ABD PAIN		789		
O.V. BRIEF (10)	7	90000	2 90040	47 SURGERY ASSIST		ABUSION		919		
O.V. LIMITED (15)	8	90010	3 90050	47 OB TOTAL CARE	59400	ALLERGY		995.3		
O.V. INTERMEDIATE (20)	9	90015	4 90060	47 OB PRENATAL ONLY	59420	ANEMIA		285.9		
O.V. EXTENDED (30)	10	90017	5 90070	47 OB DELIVERY ONLY	59410	ARTHRITIS		716.9		
O.V. COMPREHENSIVE (50)	11	90020	6 90080	47 LACERATION	12002	ASCVD		414		
L & A ACCIDENT REPORT			90001	47 FRACTURE		ASTHMA		493		
EPST greater than 1 YEAR	43		09000	47 CASTING	29	ATS		300		
EPST less than 1 YEAR	43		09011	47 CIRCUMCISION NEWBORN	54150	BRONCHITIS		490		
COUNSELING	43		908	47 VASECTOMY	55250	HURN		949		
OB VISIT (PRL)	43		90401	47 BIOPSY		RUHSITIS		727.3		
OB VISIT (NOT PRL)	43		90050	47 CORNEAL FOREIGN BODY	65220	CELLULITIS		682.9		
SPORTS PHYSICAL	43		8 90040	47 SIGMOIDOSCOPY	40240	H/O CERVICAL CANCER		184.9		
NEWBORN P/D (PRL)	43		43	47 IUD INSERT	58300	CHEST PAIN		780		
PHE OP VISIT	43		43	47 ENDOMETRIAL BIOPSY	58100	CHF		428		
	43		43	47 TUBAL LIGATION	58600	CONJUNCTIVITIS		372		
				47 TUBAL LIGATION PARTUM	58605	CONTUSION		924.9		
				47 D & C	58120	CORNEAL ABRAS		918		
				47 LUMBAR PUNCTURE	62270	COPD		492		
				47 SPINAL ANESTHESIA	62274	DEPRESSION		300.4		
				47 CESARIAN SECTION	59500	DERMATITIS		692.9		
				47 CHYROSURGERY	171	DIABETES		250		
				47 I & D ABCESS	10060	FAMILY PLANNING		V25		
				47 COLONOSCOPY	40220	FOREIGN BODY				
				47 COLONOSCOPY W/BIOPSY	40225	FRACTURE				
SPECIAL PROCEDURES				LABORATORY				DIAGNOSIS		
EKG INTER	48	93042	48 93042	45 SKIN CULTURE	87101	GASTROENTERITIS		009.0		
EKG FULL	48	93000	48 93000	45 G.C. CULTURE	87081	HEADACHE		784		
EKG RHYTHM	48	93040	48 93040	22 BLOOD SUGAR	82947	HEMORRHOIDS		774		
PULMONARY FUNC	48	94010	48 94010	45 GRAM STAIN	87205	HYPERTENSION		401		
PULMONARY FUNC B & A	48	94060	48 94060	13 GUAIAC TEST	89205	LACERATION		879.8		
DIATHERMY	48	97000	48 97000	14 HEMATOCHIT	85014	LOW BACK PAIN		724.3		
ALLERGY TESTING	48	98011	48 98011	45 MONO SPOT	86006	MENOPAUSE SYN		627.2		
TONOMETRY	48	92100	48 92100	35 PHEG TEST	82996	MENSTRUAL DIS		626		
BSST STRESS TEST	48	99021	48 99021	45 URINE C & S	87184	OBESITY		278		
AMNIOCENTESIS	48	99000	48 99000	36 THROAT/STREP CUL	87060	OTITIS EXTERNA		380		
ACUPUNCTURE	48	96300	48 96300	37 URINE COLONY COUNT	87086	OTITIS MED ACUTE		381		
AUDIOSHAM	48	92562	48 92562	38 U A	81000	OTITIS MED CHRON		382		
TYMPANOMETRY	48	92567	48 92567	39 WET MOUNT KOH	87210	PHARYNGITIS		462		
AUDIO & TYMP	48	92568	48 92568	45 WBC	85048	PHYSICAL EXAM		V70		
TRIGGER POINT INJECTION	48	20550	48 20550	45 G.T.T. X	82951	PID		614		
ULTRASOUND	48		48	21 PAP SMEAR	88150	PNEUMONIA		486		
						PHOSPHATITIS		601		
						SINUSITIS		461		
						SKIN INFECTION		686		
						SKIN LESION		709		
						STRAIN OF SPRAIN				
						THYROID PROBLEM		246.9		
						TONSILLITIS		463		
						UTI		595		
						ULCER		533		
						URETHRITIS		597		
						URI		460		
						VIRAL SYND		079.9		
						VAGINITIS				
						PREGNANCY		V22		

2 1/2 cm laceration (R chin - during splen)

STAFF INSTRUCTIONS

PATIENT INSTRUCTIONS

HOSPITAL INSTRUCTIONS

CASH
BANK
CHECK
INS

CURRENT BALANCE

TODAY'S FEES

AMOUNT PAID

NEW BALANCE

60.00

RETURN _____ DAYS 10
_____ WEEKS 20
_____ MONTHS 30

MID-COLUMBIA FAMILY HEALTH CENTER

FOR _____
WITH _____
MON TUES WED THUR FRI SAT A.M.
DATE _____ TIME _____ P.M.

TO CANCEL, PLEASE CALL AT LEAST 24 HOURS
BEFORE APPOINTMENT

WHITE SALMON
493-2133

STEVENSON
427-4212

Insurance
Kaiser

SKAGANIA COUNTY, WASHINGTON
SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Supervisor must complete report and return to
Safety Division, Personnel Dept. within 24 hours

B. COMPLETED BY INJURED WORKER:

Injured worker's name Raymond L. Brien (2) Date of accident 7-24-84
Job Title Crewman (5) Time of accident 3:15
Department Skamania Co. Fire Dept. (6) Witnesses (if any) Ray Brien

Was first aid given? Yes ☐ No ☒ (7a) Name of first aider Ray Brien
Hospitalized? Yes ☐ No ☐ (8a) Name of hospital or MD Porter Hill
Did injured worker refuse first aid? 911 Medical attention 911 (answer yes/no)

(1) Nature/extent of injuries 911 in mountain area

(a) Was this part of body previously injured? Yes ☐ No ☒ If yes, when?

(b) Was previous injury on the job? Yes ☐ No ☐ If yes, name employer

(c) Was a comp. claim filed? Yes ☒ No ☐ If yes, what was the result

(2) Location accident/exposure occurred (be specific) on Jones Road near Rd

(3) Job or activity engaged in at time of injury stationing hose on State Road

(4) Was activity a normal part of the job? Yes ☒ No ☐ If no, explain why it was being done:

(5) How did accident/exposure occur? (be specific) while stationing hose on State Road
and hose

SIGNATURE OF INJURED WORKER: Raymond L. Brien DATE 7-24-84

C. BE COMPLETED BY SUPERVISOR/LEADPERSON:

(1) Were specific safety instructions given prior to starting job? Yes ☐ No ☐
Not required ☒ Given, but not followed:

(2) Was any personal protection required? Yes ☐ No ☒ If yes, describe (safety shoes, safety glasses, etc.)

(3) Were guards/safety devices available? Yes ☐ No ☐ Available, but not used
Not adequate ☒

(4) Describe any unsafe conditions related to accident/exposure:

(5) Describe any unsafe methods or practices related to accident/exposure:

(6) Corrective action (check one)

☒ The corrective action I have taken is: Installing new Porters Press
 fittings on hose

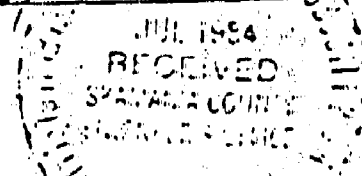
☐ The planned corrective action is: This hose will NOT be used until
new hose or connectors are installed Target date: 8-11-84

Assistance is requested from Safety Department

(7) Did the injured worker miss any time off from work due to this incident? Yes ☐ No ☒
If yes, what dates and how many hours for such dates

(8) Do you anticipate any future time off

SIGNATURE OF SUPERVISOR: Le. D. Modder DATE 7-24-84



Incident/Accident No. 1984-8

When starting the pump on water truck, a four inch hose blew away from the pump, hitting workman in the mouth and jaw.

A statement was attached by the Supervisor, that the connector will not be used until it has been factory repaired.



KING BEARING, INC.

More than just a distributor

(503) 222-6300

2515 N.W. NICOLA STREET • PORTLAND, OR 97210

The base that I have seen the same
section will not be used until it has
been in-line Portland. Some of the
equipment in the that the Circle has been
like the base that I will have to
be in line.

[Signature]

is Gary Woodruff
Rough he was also in the chie
of the several other things. His name
is Gary Woodruff

Toll Free 1 (800) 452-0351