99213

MAY 1985 RECEIVED SKAMANIA COUNTY

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 G 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~~ July day of 24 1984.

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, on a Co. Truck blew off, had been glued on & Ray Bliss was checking it out.

4. That the injury is described as follows: Ray 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: 60.00 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, 1985

Gary W Wendell
(Claimant)

MID-COLUMBIA FAMILY HEALTH CENTER

216 ☐ WHITE SALMON OFFICE ☐ STEVENSON OFFICE

P.O. BOX 1519, WHITE SALMON, WASHINGTON 98672 — 493-2133
P. O. BOX 390, STEVENSON, WASHINGTON 98648 — 427-4212

☐ 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:

Gary Wendell
Box 5-36
Carson, WA 98610

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

SKA Co Accident

SS# 368-42-3268

5:30 PM

IRS #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 NAMED ABOVE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. (IF THE PATIENT IS A MINOR, SIGN BY PARENT OR GUARDIAN)

SIGNED X Accident Insurance

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		ESTAB	CHARGE
OFFICE					
O.V. - MINIMAL (5)			1	90030	
O.V. BRIEF (10)	7	90000	2	90040	
O.V. LIMITED (15)	8	90010	3	90050	
O.V. INTERMEDIATE (20)	9	90015	4	90060	
O.V. EXTENDED (30)	10	90017	5	90070	
O.V. COMPREHENSIVE (50)	11	90020	6	90080	
L & I ACCIDENT REPORT				90001	
EPSDT greater than 1 YEAR	43		43	09000	
EPSDT less than 1 YEAR	43		43	09011	
COUNSELING	43		43	908	
OB VISIT (Pkg)	43			59401	
OB VISIT (No Pkg)	43		43	99050	
SPORTS PHYSICAL	43		8	90040	
NEWBORN F/U (Pkg)	43		43		
PRE-OP VISIT	43		43		
SPECIAL PROCEDURES					
EKG INTLH	48	93042	48	93042	
EKG FULL	48	93000	48	93000	
EKG RHYTHM	48	93040	48	93040	
PULMONARY FUNC	48	94010	48	94010	
PULMONARY FUNC B & A	48	94060	48	94060	
DIATHERMY	48	97000	48	97000	
ALLERGY TESTING	48	95011	48	95011	
TONOMETRY	48	92100	48	92100	
BSST STRESS TEST	48	93021	48	93021	
AMNIOCENTESIS	48	59000	48	59000	
ACUPUNCTURE	48	96900	48	96900	
AUDIOGRAM	48	92552	48	92552	
TYMPANOMETRY	48	92567	48	92567	
AUDIO. & TYMP	48	92568	48	92568	
TRIGGER POINT INJECTION	48	20550	48	20550	
ULTRASOUND	48		48		
NURSING					
25 MEDICATION INJ				90782	
26 DPT/OPV/DT/FLU				90720	
46 MMH				90723	
27 ALLERGY				95125	
28 IRRIGATE EARS				69210	
29 T.B. TEST				86580	
30 SUPPLIES				99070	
31 STERILE TRAY				99070	10.00

SERVICE	CPT #	CHARGE
SURGERY		
47 SURGERY P/O		
47 SURGERY ASSIST		
47 OB TOTAL CARE	59400	
47 OB PRENATAL ONLY	59420	
47 OB DELIVERY ONLY	59410	
47 LACERATION	12002	50.00
47 FRACTURE		
47 CASTING	29	
47 CIRCUMCISION NEWBORN	54150	
47 VASECTOMY	55250	
47 BIOPSY		
47 CORNEAL FOREIGN BODY	65220	
47 SIGMOIDOSCOPY	45240	
47 IUD INSERT	58300	
47 ENDOMETRIAL BIOPSY	58100	
47 TUBAL LIGATION	58600	
47 TUBAL LIGATION P-PARTUM	58605	
47 D & C	58120	
47 LUMBAR PUNCTURE	62270	
47 SPINAL ANESTHESIA	62274	
47 CESARIAN SECTION	59500	
47 CRYOSURGERY	171	
47 I & D ABCESS	10060	
COLONOSCOPY	45220	
47 COLONOSCOPY W/BIOPSY	45225	
LABORATORY		
45 SKIN CULTURE	87101	
45 G. C. CULTURE	87081	
22 BLOOD SUGAR	82947	
45 GRAM STAIN	87205	
33 GUAIAC TEST	82270	
34 HEMATOCRIT	85014	
45 MONO SPOT	86000	
35 PREG TEST	84996	
45 URINE C & S	87184	
36 THROAT/STREP CUL	87060	
37 URINE COLONY COUNT	87086	
38 U.A.	81000	
39 WET MOUNT KOH	87210	
45 W.B.C.	85048	
45 G.T.T. X	82951	
21 PAP SMEAR	88150	

DIAGNOSIS FOR INSURANCE		
DX = ICDA IF CODED HO		HULL OUT
DIAGNOSIS	ICDA	HO
ABD. PAIN	789	
ABRASION	919	
ALLERGY	995.3	
ANEMIA	285.9	
ARTHRITIS	716.9	
ASCVD	414	
ASTHMA	493	
ATS	300	
BRONCHITIS	490	
BURN	949	
BURSITIS	727.3	
CELLULITIS	682.9	
H/O CERVICAL CANCER	184.9	
CHEST PAIN	786	
CHF	428	
CONJUNCTIVITIS	372	
CONTUSION	924.9	
CORNEAL ABRAS	918	
C.O.P.D	492	
DEPRESSION	300.4	
DERMATITIS	692.9	
DIABETES	250	
FAMILY PLANNING	V25	
FOREIGN BODY		
FRACTURE		
GASTROENTERITIS	009.0	
HEADACHE	784	
HEMORRHOIDS	774	
HYPERTENSION	401	
LACERATION	879.8	
LOW BACK PAIN	724.5	
MENOPAUSE SYN.	627.2	
MENSTRUAL DIS	626	
OBESITY	278	
OTITIS EXTERNA	380	
OTITIS MED. ACUTE	381	
OTITIS MED. CHRON.	382	
PHARYNGITIS	462	
PHYSICAL EXAM	V70	
PID	614	
PNEUMONIA	486	
PROSTATITIS	601	
SINUSITIS	461	
SKIN INFECTION	686	
SKIN LESION	709	
STRAIN or SPRAIN		
THYROID PROBLEM	246.9	
TONSILLITIS	463	
U.T.I.	595	
ULCER	533	
URETHRITIS	597	
URI	460	
VIRAL SYND.	079.9	
VAGINITIS		
PREGNANCY	V22	

2½ cm laceration (R) chin - 2 sutures

STAFF INSTRUCTIONS

PATIENT INSTRUCTIONS

CASH / BANK / CHECK / INS:

CURRENT BALANCE
TODAY'S FEES 60.00
AMOUNT PAID
NEW BALANCE

HOSPITAL INSTRUCTIONS

Insurance
Kaiser

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

SKAMANIA 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 [illegible] (2) Date of accident 7-24-84

Job Title [illegible] (4) Time of accident 3:15

Department [illegible] (6) Witnesses (if any) [illegible]

Was first aid given? Yes ___ No X (7a) Name of first aider ___

Hospitalized? Yes ___ No ___ (8a) Name of hospital or MD [illegible]

Did injured worker refuse first aid? No Medical attention ___ (answer yes/no)

) Nature/extent of injuries [illegible]

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

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

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

) Location accident/exposure occurred (be specific) [illegible]

) Job or activity engaged in at time of injury [illegible]

) Was activity a normal part of the job? Yes X No ___ If no, explain why it was being done: ___

) How did accident/exposure occur? (be specific) [illegible]

SIGNATURE OF INJURED WORKER: [signature] DATE 7-24-84

BE COMPLETED BY SUPERVISOR/LEADPERSON:

5) Were specific safety instructions given prior to starting job? Yes ___ No ___
Not required ✓ Given, but not followed: ___

6) Was any personal protection required? Yes ___ No ✓ If yes, describe (safety shoes, safety glasses, etc.) ___

7) Were guards/safety devices available: Yes ___ No ___ Available, but not used ___
Not adequate ✓

8) Describe any unsafe conditions related to accident/exposure: ___

9) Describe any unsafe methods or practices related to accident/exposure: ___

0) Corrective action (check one)
✓ The corrective action I have taken is: Installing New Factory Pressure 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

1) 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
None

2) Do you anticipate any future time off No

SIGNATURE OF SUPERVISOR: [signature] DATE 7-24-84

REV. 6/82

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.

This hose that blew off the [illegible] [illegible] will not be used until it has been [illegible] Portland. Some of the [illegible] that this could happen [illegible] I will have to [illegible]

[illegible]

P.S. [illegible] was [illegible] Rep. he was [illegible] the [illegible] [illegible] taken. His name is Gary [illegible]