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FILED FOR RECORD
SKAMANIA CO. WASH
BY Skamania County
JUN 16 4 33 PM '97
P. Lowry
AUDITOR
GARY M. OLSON

Return Address:

Skamania Co. Auditor

Please Print or Type Information.

Document Title(s) or transactions contained therein:

1. Tort Claim Form
2. Claim for Damages
3.
4.

GRANTOR(S) (Last name, first, then first name and initials)

1. Skamania County
2.
3.
4.

[ ] Additional Names on page _____ of document.

GRANTEE(S) (Last name, first, then first name and initials)

1. Long, Jerome Paul
2.
3.
4.

[ ] Additional Names on page _____ of document.

LEGAL DESCRIPTION (Abbreviated: I.E., Lot, Block, Plat or Section, Township, Range, Quarter/Quarter)

[ ] Complete legal on page _____ of document.

REFERENCE NUMBER(S) Of Documents assigned or released:

[ ] Additional numbers on page _____ of document.

ASSESSOR'S PROPERTY TAX PARCEL/ACCOUNT NUMBER

[ ] Property Tax Parcel ID is not yet assigned.
[ ] Additional parcel #s on page _____ of document.

The Auditor/Recorder will rely on the information provided on the form. The Staff will not read the document to verify the accuracy or completeness of the indexing information.

STANDARD TORT CLAIM FORM

Pursuant to RCW 4.92, this form is provided for your convenience when filing a tort claim against the State of Washington. If filing a claim involving an accident with a vehicle operated by a state employee, please complete a Standard Vehicle Accident Claim Form (SF 138) in lieu of this and forward that form to the Division Of Risk Management.

Mail or deliver original claim in duplicate to:

Detartment of General Administration
Division of Risk Management
301 General Administration Building
Post Office Box 41027, MS: 41027
Olympia, WA 98504-1027

For official use only
DRM No. ______

Applicable to Dept. of Corrections inmate
Resident NO ______
Institution ______

PLEASE TYPE OR PRINT IN INK

PERSONAL INFORMATION

1. Claimant's name:
LONG JEROME PAUL 6-27-57 534623613
Last name First Middle Date of Birth(M-D-Y) SS NO.

2. Current Residential address: 1830 EAGLE CREST WAY DOC# 926133 J-B-9
CLALLAM BAY, WA. 98326

3. Mailing address(if different) ______

4. Residential address for six months prior to the date of incident:
66 RUSSEL AVE. PLAZA
STEVENSON, WA. 98648

5. Claimant's daytime telephone number: (360) 963-3237 Home (___) ______ Business

INCIDENT INFORMATION

6. Date of incident:(first occurred) 3/18/97 Time 11 A.M./P.M.(circle 1)

7. If incident occurred over a period of time, date of last occurrence:
2/24/97 Time 11 A.M./P.M.(circle 1)

8. Location of incident: WA SKAMANIA STEVENSON JAIL
State & County City Place where occurred

9. If incident occurred on a street or highway: 240 NW. VANCOUVER AVE.
name of street or highway
______
Milepost number At the intersection with/nearest intersecting street

10. State agency or department alleged responsible for damage/injury:
Skamania County Jail

11. Names, addresses and telephone numbers of all persons involved in or a witness to this incident: Jailer Sally D.

12. Names, addresses, and telephone numbers of all state employees having knowledge about this incident: Jailer Sally D.

13. Names, addresses and telephone numbers of any and all individuals not already identified in #11 & #12 above that have knowledge regarding the liability issues involved in this incident, and/or the claimant's damages that were caused by this incident. Please include a brief description as to the nature and extent of each person's knowledge. Attach additional sheets if necessary.

14. Describe conduct and circumstances causing injury or damages, explaining extent of medical. physical or mental injuries. Attach additional sheets if necessary. Skamania County Jail Took money off my books for 2 meds. I told Sally D. the jailer Doc. pays medical Bills then Ska. Co. jail took money off a third time. Rx 216392 Rx 216393 Rx 216647

15. Name, address and telephone number of treating medical provider(s). (Attach copies of all medical reports and billings):

16. I/We do hereby claim damages from the State of Washington in the sum of $ 39.57 .

<u>Claimant must sign this claim form.</u> If the claimant is incapacitated from verifying, presenting, and filing the claim, or if the claimant is a minor, or is a nonresident of the state, the claim may be verified, presented and filed on behalf of the Claimant by any relative, attorney, or agent representing the claimant.

I certify or "declare" under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Jerome Paul Gray	6-12-97 C.B.C.C. Clallam Bay Clallam
signature of Claimant	Date and place(residential address, city & county)

If necessary, attach additional pages containing information in this format. The Division of Risk Management does not accept the filing of tort claims via Facsimile(FAX).

COPY OF ORIGINAL DOCUMENT

DEPUTY

WIND RIVER PHARMACY
256 2nd Street
STEVENSON, WA 98648
(509) 427-5480

DATE	PHYSICIAN
2/18/97	

NAME: Skamania Co. Jail

ADDRESS: PO Bx 790 Stev WA 98648

TAKEN BY	FILLED BY	CASH	CHARGE	C.O.D.	ON ACCT.	WILL CALL	DELIVER

RX 216392	13.49
Rx 216393	6.89
For: (Jerome Long)	
TAX	
TOTAL	20.38

RECEIVED BY X

3817

SAVE THIS SLIP – Many items can be deducted from your Taxable Income

Thank You

SERIES 606

COPY OF ORIGINAL DOCUMENT

DEPUTY

WIND RIVER PHARMACY
256 2nd Street
STEVENSON, WA 98648
(509) 427-5480

DATE 2/24/97 PHYSICIAN

NAME Skamania Co. Jail

ADDRESS PO Box 790 Stev. WA 98648

TAKEN BY	FILLED BY	CASH / CHARGE	ON ACCT.	WILL CALL	DELIVER

RX 216647	19.19
For (Jerome Long)	
TAX	—
TOTAL	19.19

RECEIVED BY X

SAVE THIS SLIP - Many items can be deducted from your Taxable Income. *Thank You*

3831

SERIES 806