

SKAMANIA COUNTY CLAIM FOR DAMAGE FORM

CLAIMANT: THIS CLAIM MUST BE FILED WITH THE	FOR OFFICE USE ONLY:
SKAMANIA COUNTY CLERK OF THE BOARD Skamania County Auditor's Office Skamania County Courthouse 240 North West Vancouver Avenue, Room 27 Stevenson, WA 98648	CLAIM NO. _____ DATE FILED: _____ COPIES TO: _____
NO DAMAGES CAN BE PAID BY SKAMANIA COUNTY UNLESS THIS FORM IS COMPLETE. THIS PROVISION CANNOT BE WAIVED.	ATTACHMENTS: YES(#) NO

1. Name (including spouse if married): (Please Print)
GUY BIESANZ
2. PO Box 63 CARSON WA 98610
Address City State Zip
3. HM Phone: 427-5139 WK Phone: 427-7272 MSSG Phone: 909-6184³⁶⁰
4. Date and time of incident: 10/13/06 9:00 AM
5. Location of incident:
ROCK COVE ASSISTED LIVING
986 N.W. ROCK CREEK DRIVE STEVENSON
6. Describe in narrative form and in detail exactly how the incident occurred:
I WAS REPAINTING THE PARKING LOT LINES. MY DOG, CHIMO, WAS WITH ME AS ALWAYS AND LAID DOWN NEAR MY WORK AREA. SUE ENTERED THE PARKING LOT, I WAS KEEPING A CLOSE EYE ON CHIMO, SUE DID NOT SEE CHIMO OR ME TRYING TO STOP HER. SUE RAN OVER CHIMO AND CAME TO A STOP 8 FEET FROM ME.
7. What is the amount of damages claimed arising out of the following circumstances (Include estimates and bills, if available): VET BILL \$735.12 CLINIC
BILL \$360.60 PHARMACY \$127.92 TOTAL = \$1223.64

8. Please list name and address of any and all witnesses or persons involved:
(Please Print)

SUE PENNER
PANTHER CREEK RD.
CARSON, WA. 98610

9. Describe the damages or injuries you sustained as a result of the incident:

THE LOSS OF MY DOG OF 15 YRS AND DOG BITE TO
MY RIGHT HAND AND CHIN

10. Was incident investigated by a police officer? Sheriff _____ State Patrol _____
City _____

NO

11. If a vehicle was involved in the incident, describe: Make JEOP
Model CHEROKEE Year _____ State WA License No. SUZI P
Insurance Company _____ Policy Number _____

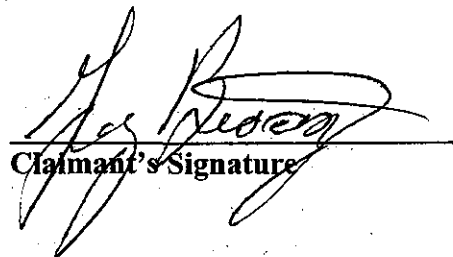
12. Describe what you did after the incident occurred: I PUT SHINO IN
SUES CAR. TOOK HER TO THE VET AND THEN
MYSELF TO THE CLINIC.

13. Describe the conversations you had, if any, with County personnel during or after the incident occurred. SUE WAS SORRY SAID SHE DID NOT
SEE MY DOG. I SAID I WOULD NEED HELP
WITH THE BILLS INVOLVED AND SUE AGREED

14. How did you identify the County as the party responsible for your damage?
I DID NOT SUE PENNER DID THIS.

I certify under penalty of perjury under the laws of the State of Washington that the information contained in this claim is true and correct.

DATED THIS 31 DAY OF OCTOBER, 2006


Claimant's Signature

File Name: Commiss/Risk Mang/Claims/Claim For Damages

NOTE: Personal property (car, etc.) damages are to be accompanied by 2 estimates for repair costs. The Skamania County Risk Manager will investigate this claim. The decision to honor this claim will be based upon that investigation. Making a false report or providing false evidence is a crime and punishable by fine and/or imprisonment. Additional pages may be attached if needed to answer the questions.

INVOICE

Stevenson Veterinary Clinic

7101 E. Loop Rd.
Stevenson, WA 98648
(509) 427-8763

"Your other Family Doctor"

FOR: Guy Biesanz
P.O. Box 63
Carson, WA. 98610

Printed: 10-13-06 at 11:28a
Date: 10-13-06
Account: 923
Invoice: 8944

Date	For	Qty	Description	Price
10-13-06	Chimo	1	Physical Exam	33.25
10-13-06		1	Dental Exam	0.00
10-13-06		2	Pre-Anesthetic 1ml	24.28
10-13-06		1.50	Metacam Injectable	39.96
10-13-06		1	IV Catheterization	37.65
10-13-06		1	IV Catheter 18g	2.50
10-13-06		1	IV Set 106" Life Shield	4.52
10-13-06		1	IV Fluids - First Bag	28.00
10-13-06		1	IV Fluids-Additional Bag	20.00
10-13-06		1	Solu Delta Cortif 100mg Injectable	36.50
10-13-06		1	X-Ray Large	60.50
10-13-06		4	X-Ray Added Large	162.00
10-13-06		1	Euthanasia 101-149lbs	125.00
10-13-06		1	Cremation 101 - 120Lbs	130.96
10-13-06		1	Save Ashes	30.00

Total charges, this invoice...	735.12
Your old balance...	0.00
Your new balance...	735.12

NOTICE NEW POLICY: Accounts over 30 days will be charged a service charge of 2 percent per month on the unpaid balance as well as a \$3.25 statement fee.



Guy,

If you need to make payments please let us know.

Joann

Mid-Columbia Family Health Center

212 Skyline Drive
P.O. Box 1519
White Salmon, WA 98672

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
CHECK CARD USING FOR PAYMENT		
 <input type="checkbox"/> MASTERCARD  <input type="checkbox"/> VISA		
CARD NUMBER	AMOUNT	
SIGNATURE	EXP. DATE	
STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
10/26/06	\$360.60	7104
SHOW AMOUNT PAID HERE		\$

STATEMENT**ADDRESSEE:**

BIESANZ, GUY C
PO BOX 63
CARSON, WA 98610
USA

REMIT TO:

Mid Columbia Family Health Center
PO Box 1519
White Salmon, WA 98672

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	DESCRIPTION OF SERVICE	AMOUNT	INSUR BALANCE	PATIENT BALANCE	BALANCE
10/13/06	ENCOUNTER FOR GUY WITH NICKOLAS PA-C, CHRISTINA				
10/13/06	12011 - Simpl Repr Face/mucous; 2.5/le	\$261.00		\$261.00	
10/13/06	90718 - Tetanus/diphth Tox-adult-im/jc	\$17.00		\$17.00	
10/13/06	J0696 - ROCEPHIN (Ceftriaxone) Inj-Per 250 (QTY 4)	\$22.60		\$22.60	
	ENCOUNTER TOTAL	\$300.60	\$0.00	\$300.60	\$300.60
10/18/06	ENCOUNTER FOR GUY WITH NICKOLAS PA-C, CHRISTINA				
10/18/06	99212 - Office/outpt E&m Estab Minor 10	\$60.00		\$60.00	
	ENCOUNTER TOTAL	\$60.00	\$0.00	\$60.00	\$60.00

ACCOUNT NBR	CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS	TOTAL ACCOUNT BALANCE
7104	\$360.60	\$0.00	\$0.00	\$0.00	\$0.00	\$360.60

MESSAGE:

If you are receiving MULTIPLE STATEMENTS for one household please let us know. (509)493-9530 Monday through Friday between 8:am and 5:00pm.
Mid Columbia Family Health Center

**PLEASE PAY
THIS AMOUNT >>>> \$360.60**

**** PAYMENT DUE UPON RECEIPT * THANK YOU **
STATEMENT**

WIND RIVER PHARMACY INC #1173
280 2ND STREET
STEVENSON, WA 98848 (509) 427-5480

Rx# 528795
10-13-06

For: GUY BIESANZ
PO BOX 433
CARSON, WA

RECEIPT
SAVE FOR INSURANCE
OR TAX RECORDS

98610-0000 427-7002

GUY BIESANZ
PO BOX 433
CARSON, WA

98610-0000

AMOX/CLAV 875/125MG TAB 875MG
#20 NDC: 00093-2275-34
DR. NICKOLAS, CHRISTINA



Price \$64.78

WIND RIVER PHARMACY INC #1173
280 2ND STREET
STEVENSON, WA 98848 (509) 427-5480

Rx# 529080
10-18-06

For: GUY BIESANZ
PO BOX 433
CARSON, WA

RECEIPT
SAVE FOR INSURANCE
OR TAX RECORDS

98610-0000 427-7002

GUY BIESANZ
PO BOX 433
CARSON, WA

98610-0000

AMOX/CLAV 875/125MG TAB 875MG
#14 NDC: 00093-2275-34
DR. NICKOLAS, CHRISTINA



Price \$52.19

WIND RIVER PHARMACY INC #1173
280 2ND STREET
STEVENSON, WA 98848 (509) 427-5480

Rx# C528796
10-13-06

For: GUY BIESANZ
PO BOX 433
CARSON, WA

RECEIPT
SAVE FOR INSURANCE
OR TAX RECORDS

98610-0000 427-7002

GUY BIESANZ
PO BOX 433
CARSON, WA

98610-0000

HYDROCO/APAP 5-500MG TAB
#15 NDC: 00591-0349-05
DR. NICKOLAS, CHRISTINA



Price \$10.95