AFN #2018001102 Recorded May 29, 2018 02:59 PM DocType: MISC Filed by: SKAMANIA COUNTY HOSPITAL DISTRICT Page: 1 of 4 File Fee: $77.00 Auditor Robert J. Waymire Skamania County, WA

WHEN RECORDED RETURN TO:

Skamania County EMS
PO Box 338
Stevenson, WA 98648

DOCUMENT TITLE(S)

RESOLUTION 2018-04

REFERENCE NUMBER(S) *of Documents assigned or released:*

[ ] Additional numbers on page _____ of document.

GRANTOR(S):

Skamania County Public Hospital District

[ ] Additional names on page _____ of document.

GRANTEE(S):

N/A

[ ] Additional names on page _____ of document.

LEGAL DESCRIPTION *(Abbreviated: i.e. Lot, Block, Plat or Section, Township, Range, Quarter):*

Appointment of Agent to Receive Claims

[ ] Complete legal on page _____ of document.

TAX PARCEL NUMBER(S):

N/A

[ ] Additional parcel numbers on page _____ of document.

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

LPB 01-05

SKAMANIA COUNTY PUBLIC HOSPITAL DISTRICT No.1

RESOLUTION 2018-04
Rescinding Resolution 2017-01 and
Appointing an Agent to Receive Claims for Damage
(RCW 4.96.020)

WHEREAS, the Board of Commissioners for Skamania County Public Hospital District held their regularly scheduled business meeting on April 23, 2018 and;

WHEREAS, the Board of Commissioners pursuant to the provisions of RCW 4.96.020 the governing body of each local governmental entity shall appoint an agent to receive any claim for damages made under Chapter 4.96, and;

WHEREAS, the identity of the agent and the address where he/she may be reached during the normal business hours of the local government entity are public records and shall be recorded with the auditor of the county in which the entity is located, and;

WHEREAS, all claims for damages against a local governmental entity, or against any local governmental entity's officers, employees or volunteers, acting in such capacity, shall be presented to the agent with the applicable period of limitations within which an action must be commenced, and;

WHEREAS, the failure of a local governmental entity to comply with the requirements of this section precludes that local governmental entity from raising a defense under Chapter 4.96 RCW;

NOW, THEREFORE be it resolved that the Board of Commissioners for Skamania County Public Hospital District does hereby rescind Resolution 2017-01, and appoints the agent listed below to receive any future claims for damages made under Chapter 4.96 RCW.

Agent:	Ann Lueders, Superintendent **OR** On Duty Shift Captain
Office Address:	PO BOX 338 253 SW First Street Stevenson, WA 98648
Business Hours:	Monday – Thursday 7:00am to 6:00pm
Appointment Term:	beginning 23rd of April 2018 and remaining in effect until changed and later recorded by the Board of Commissioners

BE IT FURTHER RESOLVED, that the Board of Commissioners for Skamania County Public Hospital District do hereby adopt the attached Claim for Damage Form and that such form and this Resolution are to be recorded with the Auditor, Skamania County.

PASSED IN REGULAR SESSSION this 23 day of April, 2018.

BOARD OF COMMISSIONERS
SKAMANIA COUNTY PUBLIC HOSPITAL DIST. No. 1

Chairman Commissioner Commissioner

CLAIMANT THIS CLAIM MUST BE FILED WITH:

SKAMANIA COUNTY PUBLIC HOSPITAL DISTRICT
P.O. BOX 338
253 SW First Street
Stevenson, WA 98648

Office Hours: Monday – Thursday
between 7:00am and 6:00pm

FOR OFFICE USE ONLY:

CLAIM NO.

DATE FILED:

COPIES TO:

NO DAMAGES CAN BE PAID BY SKAMANIA COUNTY PUBLIC HOSPITAL DISTRICT # 1 UNLESS THIS FORM IS COMPLETE. THIS PROVISION CANNOT BE WAIVED.

ATTACHMENTS: YES (#___) NO___

PLEASE COMPLETE ALL SECTIONS, PLEASE PRINT CLEARLY

1. Name (including spouse if married):

_____

2. _____
Mailing Address City State Zip

_____
Physical Address City State Zip

3. HM Phone:_____ WK Phone:_____ MSSG/MOBILE:_____

4. Date and time of incident:_____

5. Location of incident:

_____

_____

6. Describe in narrative form and in detail exactly how the incident occurred:

_____

_____

_____

_____

_____

7. What is the amount of damages claimed arising out of the following circumstances (Include estimates and bills, if available):_____

_____

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

_____

_____

_____

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

_____

_____

_____

10. Was incident investigated by a police officer? Yes___ No___ (Indicate which below)

Sheriff_____ State Patrol_____ City_____

11. If a vehicle was involved in the incident, describe: Make_____
Model_____ Year_____ State_____ License No._____
Insurance Company _____ Policy Number_____

12. Describe what you did after the incident occurred:_____

_____

_____

_____

13. Describe the conversations you had, if any, with agency personnel during or after the incident occurred._____

_____

14. How did you identify the agency as the party responsible for your damage?

_____

_____

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 _____DAY OF _____, 20___ ATTACHMENTS: YES (#___) NO___

_____
Claimant's Signature

_____
Print Name of Claimant

NOTE: **Personal property (car, etc.) damages are to be accompanied by 2 estimates for repair costs.** The Skamania County Public Hospital District and other applicable agencies 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.