To Whom It May Concern:

Enclosed, please find a "Claim Against a Public Entity" form. The completed form should be returned to the address located at the top of the form.

Washington Hospital is a public entity that operates under Washington Township Health Care District (the “District”). Our District is governed by a publicly elected Board of Directors. Once your claim form is received it will be processed accordingly. The Hospital’s Board of Directors will review your claim and respond to you in writing within 45 days, as required by the applicable Government Code Sections.

Please be advised that the physicians who practice at Washington Hospital and the physicians of Washington Radiologists Medical Group are independent contractors and not a part of Washington Hospital. Accordingly, they may be the best resource to respond to any concerns you have regarding the services received.

Correspondence by electronic format of this information, including email and facsimile transmission, does not indicate agreement, acceptance or consent by Washington Township Health Care District, Washington Hospital Healthcare System, and Washington Hospital to acceptance receipt of documents, forms or service of process in any electronic format.

Very Truly Yours,

Sharron Pullium
Legal Analyst
Washington Hospital Healthcare System
A part of Washington Township Health Care District

Enclosure

Claim Against Public Entity

WASHINGTON TOWNSHIP HEALTH CARE DISTRICT
Washington Hospital
2000 Mowry Avenue, Fremont, California 94538
Kimberly Hartz, Chief Executive Officer

1.	Name of claimant:		
	Home address:	*Street*	
		City, state, postal code	*Telephone* ( ) -
	Business Address:	*Street*	
		City, state, postal code	*Telephone* ( ) -
2.	Mailing address: (List address where all correspondence regarding this claim should be sent.)	*Name of Recipient (if other than claimant):*	
		Street	
		City, state, postal code	*Telephone* ( ) -
3.	List name, address, and phone number of witness(es). Use separate sheet for additional witnesses.		
	Name:		
	Address:	*Street*	
		City, state, postal code	*Telephone* ( ) -
4.	List the date, time, place, and other circumstances of the occurrence that gave rise to the claim asserted:		
	Date:	Time:	Place:
	Tell what happened (give complete information):		
	Note: Attach any photographs you may have regarding this claim.		
5.	Give a general description of the indebtedness, obligation, injury, damage, or loss incurred so far as it may be known at the time of presentation of claim:		
6.	Give the name(s) of the public employee(s) involved, if known:		
	1.	2.	
	3.	4.	
7.	If the actual amount of your claim is less than $10,000, indicate the exact amount of your claim. Attach an itemization and/or include copies of documents in support thereof. Amount $_____		
	If the amount of the claim exceeds $10,000, a dollar amount should not be included in this claim form. Is this is a limited civil case? Yes ____ No ____		
	Date:	Time:	Signature