

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 Health 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 Health are independent contractors and not a part of Washington Township Healthcare District. Accordingly, your physician may be the best resource to respond to regarding any concerns you have regarding 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 or Washington Health, to accept receipt of documents, forms or service of process in any electronic format.

Very Truly Yours,

Washington Health
Compliance Division
A part of Washington Township Health Care District

Enclosure

Claim Against Public Entity

WASHINGTON TOWNSHIP HEALTH CARE DISTRICT

Washington Health

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):		
	<i>Note: Attach any photographs you may have regarding this claim.</i>		
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 a limited civil case? Yes No		
	Date:	Time:	Signature