Malpractice/Medical Professional Claims Information

Revised 11/2019

Applicant/Licensee Name: _____ Application/License No. _____

Furnish information on a separate sheet for each malpractice claim. Make copies of this form if necessary.
PRINT LEGIBLY OR TYPE YOUR RESPONSE.

Name of patient: _____ **Patient DOB:**_____

Name of hospital/clinic/etc:_____ **Date of incident:** _____

Court filed? ☐ **Yes** ☐ **No** **Date of filing:** _____ **Name of court:** _____

Allegation:

Condition/diagnosis at time of incident:

Description of medical treatment rendered:

Condition of patient subsequent to treatment:

Disposition of claim (include settlement amount, if any):

Disposition by Medical Board, if applicable:

Name of insurance company:_____

Insurance company address: _____ **Phone number:** _____

Signature: _____ Date: _____