

CLAIM INFORMATION FORM

If you answered "yes" to any of the malpractice questions, please complete this form or submit a written explanation. Attach any supplemental information necessary. Please copy this form and complete for each additional claim.

1. Patient's Name: _____ Age: _____ Sex: _____
2. Date of first examination: _____
3. Please describe the pertinent details of the patient's history, examination and care, and the allegations made against you:

4. Subsequent condition or health of patient: _____
5. Date of Claim: _____
6. What Insurance Company, if any, was Involved? _____
Name: _____
Address: _____
7. Is Claim Still Pending? YES NO
8. Amount of any settlement or judgment: _____
9. Names of other Doctors and Hospital, if any, involved in the Claim or Suit:

10. Comments: _____

I hereby certify that the above information is, to the best of my knowledge, accurate and complete.

Signature of Applicant

Date