



Malpractice/Medical Professional Claims Information

Revised 7/2015

Applicant Name: _____ Application 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:

Date of incident:

Location (hospital, etc.):

Allegation:

Condition/diagnosis at time of incident:

Description of medical treatment rendered:

Condition of patient subsequent to treatment:

Disposition of Claim (Include settlement amount):

Disposition by Medical Board, if applicable:

Signature: _____ Date _____