## Medical Malpractice/Professional Liability Claims Information (Copy this form to report multiple claims)

Date of Claim/Suit:	Date You Received Notice:
State/County of Event:	Date of Event:
Court Case Number	Court Filing Date:
Court Where Filed In:	
Insurance Company (or specify if self-insured):	
Insurance Claim No. (or if self-insured write n/a):	
Claimant:	
Respondent:	
Brief Description of Allegations:	
*** Please attach/mail a copy of the Summons/Complain/Claim notice with form***	
Claim Status & Effective Date of That Status:	
Open (pending) Arbitration/Medicar	tion
Date of Closure:	
Amount of judgment or settlement \$	Amount paid on your behalf \$

\*\*\*Refer to NRS 633.527 for all requirements of reporting Malpractice Claims/Board Actions\*\*\*