

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/Medication
 Closed (settled)
 Dismissed
 Other

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*****