

Professional Liability Action Explanation Form

Please complete this form for each pending or settled professional liability action or any payment made on behalf of applicant. All questions must be answered completely. If additional sheets are required, please photocopy this page prior to completing. Please provide us with a separate sheet for each malpractice action.

Provider Name:

Does Not Apply

Note: Signature required even if checked

IDENTIFYING INFORMATION

Date of Alleged Incident:

Date Suit Filed:

Patient Name:

Patient Age:

Sex:

Location of Incident:

Your Relationship to Patient:
(Attending Provider, Surgeon, Assistant Surgeon, Consultant, etc.)

Allegation:

Liability Carrier when Incident Occurred

Additional Named Defendant(s)

CLAIM STATUS

OPEN – If open, amount being sought

CLOSED – If closed, indicate method of closing ‡

DISMISSAL

SETTLEMENT

CLOSE/DISMISSAL DATE:

JUDGMENT

Amount of settlement or judgment:

Summarize the circumstances giving rise to the action. If the action involves patient care, describe a narrative that provides your care and treatment of the patient. If additional space is necessary, attach adequate clinical detail to allow proper evaluation by a committee of physicians. Include 1) Condition and diagnosis at time of incident, 2) dates and description of treatment rendered and 3) condition of patient subsequent to treatment. **PLEASE PRINT.**

SUMMARY OF CIRCUMSTANCES

I certify that the information in this document and any attached documents is true, correct and complete.

Physician Signature

Date