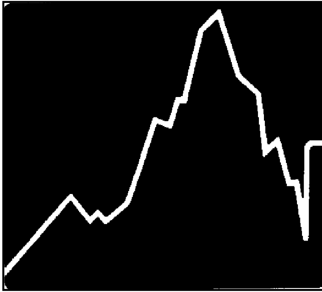
Print Name: ________________________________



Department of Health Professions
Commonwealth of Virginia

Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

Phone(804) 367-4613
FAX (804) 527-4426

CLAIMS HISTORY

If you answered "yes" to Question #14 on the application, please either have your attorney submit a letter regarding malpractice suits or complete one of these forms for each case you have been involved.

(Make additional copies of this form as needed)

Claimant: ____

Date of Incident: ______________________ ________ Date Claim Made: ______________________

Name of all Defendants, Persons or Entities against whom claim was made: ______________________

____

City, County and State of Suit: ____

Name and Address of Defense Attorney: ____

____

Settlement Amount (if any): ________________ Verdict Amount: ______________ Date Case Closed: ________________

Current Status of Claim (indicate insurance company reserve if case is not closed): ______________________

____

Name of Involved Insurance Company: ____

____

Policy Number: ______________________ Detailed Description of Claim (use reverse side if necessary): ______________________

____

____

____

____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize any person, company, insurer, hospital or other organization to release any and all information, privileged, or in their dominion, custody, or control, regarding insurance applications by me, professional liability issued to me, any employment or personnel records involving me and any health, medical psychological or psychiatric records involving me, as well as information obtained by any attorneys who are now representing, or have in the past represented me.

________________________________ ________________________________
Signature Date