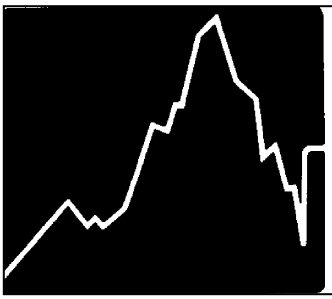
Print Name _____



Department of Health Professions
Commonwealth of Virginia

Board of Medicine
9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463 (804) 367-4613

CLAIMS HISTORY

If you answered "yes" to Question #11 on page three of 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