



Malpractice History

Provider Name: _____

Please **DUPLICATE** this form and complete for **EACH** case.

1. Patient Name: _____

2. Diagnosis:

3. Your involvement in the case, i.e... Attending, Consulting, Etc.:

4. Allegation(s):

5. Clinical Case Summary:

6. Patient Outcome: _____

7. Other pertinent details:

8. Date of incident: _____ Date filed: _____

Date closed: _____

9. Resolution of case, i.e. Dismissed, Settled Out of Court, Litigated, Pending, Other:

10. Settlement amount paid on your behalf (if any):

11. Professional liability insurer involved:

a. Name of Insurer: _____

b. Address of Insurer: _____

12. Defense attorney: _____

Signature

Date