

FORM V
“Yes” Response to Questions in
Malpractice History/Professionalism Section

If your response to Questions in this section was “Yes”:

1. For each lawsuit or settled claim, submit a statement below explaining the details
2. Submit a copy of the plaintiff’s original complaint and a copy of the disposition if the claim resulted in a suit.
3. Form I must be completed by every carrier with whom a claim has been filed.
4. If the claim/suit is still pending, have the attorney who represented you (or who is currently representing you) send a letter directly to the board regarding the allegations, defense, current status and/or outcome of the suit.

Patient’s name or initials:									
Date of injury:									
Allegation:									
Location of patient care:									
Lawsuit or Settled Claim?									
Date suit or settled claim was reported to insurer/self-insured physician:									
Date of disposition:									
Status of suit (circle one):	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Pre-Trial Settlement</td> <td style="width: 50%;">Post-Trial Settlement</td> </tr> <tr> <td>Dismissed with Prejudice</td> <td>Dismissed Without Prejudice</td> </tr> <tr> <td>Judgment after Trial</td> <td>Pending</td> </tr> <tr> <td colspan="2">Other (please specify)</td> </tr> </table>	Pre-Trial Settlement	Post-Trial Settlement	Dismissed with Prejudice	Dismissed Without Prejudice	Judgment after Trial	Pending	Other (please specify)	
Pre-Trial Settlement	Post-Trial Settlement								
Dismissed with Prejudice	Dismissed Without Prejudice								
Judgment after Trial	Pending								
Other (please specify)									
Amount of indemnity agreed upon or ordered on your behalf:									

 Applicant’s Signature

 Date

 Printed name

FORM V

Detailed summary of your involvement and role in patient care. Please use first person. Use additional paper if necessary:

Patient outcome:

Applicant's Signature

Date

Printed name