FORM I
Medical Professional Liability Claims Report

Texas Medical Board
Texas PA Board
Texas State Board of Acupuncture Examiners

File one report for each claim/suit

APPLICANT SECTION

APPLICANT:
Complete this section of this form. Give the form to your liability carrier and have them complete and return the form to you. **Once it has been returned, forward it to your Board. (Medical, PA, or Acupuncture).**.

Name:_____
Current Mailing Address:
_____
Street Address City State Zip
Date of Birth: _____
mm/dd/yyyy

LIABILITY CARRIER SECTION

Liability Carrier:
Please complete the bottom portion of this form and return the form to the applicant.

1. Name and address of Liability Carrier:
_____
_____
2. Person for whom liability was carried:
_____
3. Patient's Name:
_____
4. Plaintiff's Name: (if different from patient)
_____
5. Policy Number: _____ Type of Complaint: Claim _____ Suit ____
6. Date claim was reported to Insurer/Self-Insured Physician: _____
   Date of Injury _____
   Alleged Injury _____
7. Status of claim/suit (on this date):
_____
8. Date of Disposition: _____
9. Type of Disposition:
_____ Pre-Trial Settlement _____ Post-Trial Settlement _____ Judgment after Trial _____ Dismissed
Other (please specify) _____
10. Amount of indemnity agreed upon or ordered on behalf of this defendant
$_____.

Note: If the court or insurer in the case of multiple defendants did not determine percentage of fault, the insurer may report the total amount paid for the claim followed by a slash and the number of insured defendants
(Example: $200,000/3).

11. Appeal _____ Yes _____ No If yes, by which party:
_____
Status of appeal: _____

_____ _____
Name and Title of person completing form **Date**