

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 that was reported to your insurer within the 7 years prior to the date of submission of your TMB application. If the claim/suit was reported more than 7 years ago, a Form I is NOT required.

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 the TMB.**

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: _____

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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