

Applicant Name (Print): \_\_\_\_\_

Action Against:

CNM  NP  MD

**CLAIMS INFORMATION FORM**

The NP/CNM applicant and Supervising Physician must complete this form for **each** liability or malpractice claim. **Please make as many photocopies of this form as needed.** Complete one form for each claim or suit. **Original** signatures of the NP/CNM applicant and Supervising Physician are required on each completed form.

1. Briefly describe the details of the allegations against you. Include the patient's name, a brief history, comments regarding the examination and care surrounding the allegations. If suits are pending a very brief summary of the allegations or charges must be included regardless of the litigation state. Simply stating that the charges were dismissed is inadequate. If charges were dismissed, please provide official documentation regarding the dismissal.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Date of the claim: \_\_\_\_\_

3. If an insurance carrier was involved, list the name, address and telephone number.

\_\_\_\_\_  
\_\_\_\_\_

4. Is the claim pending?  Yes  No

5. Was there a judgment or settlement?  Yes  No

6. What was the amount and date of the judgment **OR** settlement?

Amount \_\_\_\_\_

Date \_\_\_\_\_

7. Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**I certify that the information which I have given is correct to the best of my knowledge.**

\_\_\_\_\_  
Signature/Title of Person Completing the Form  
(ORIGINAL SIGNATURE)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-Signature of NP/CNM Applicant or Supervising  
Physician  
(ORIGINAL SIGNATURE)

\_\_\_\_\_  
Date