Applicant Name (Print):_____

Action Against:
☐ CNM ☐ NP

CLAIMS INFORMATION FORM

The NP/CNM applicant 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