Medical Malpractice/Professional Liability Claims Information

(Copy this form to report multiple claims)

Date of Claim/Suit:_____ Date You Received Notice:_____

State/County of Event: _____ Date of Event:_____

Court Case Number _____ Court Filing Date: _____

Court Where Filed In: _____

Insurance Company (or specify if self-insured):_____

Insurance Claim No. (or if self-insured write n/a):_____

Claimant:_____

Respondent:_____

Brief Description of Allegations:

_____

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***** Please attach/mail a copy of the Summons/Complain/Claim notice with form*****

Claim Status & Effective Date of That Status:

☐Open (pending) ☐Arbitration/Medication ☐Closed (settled) ☐Dismissed ☐Other

Date of Closure: _____

Amount of judgment or settlement $_____ Amount paid on your behalf $ _____

*****Refer to NRS 633.527 for all requirements of reporting Malpractice Claims/Board Actions*****

Nevada State Board of Osteopathic Medicine
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