TTG Locum Tenens, Inc.
Malpractice Claims Information Form

All information presented on this form will be kept confidential and only presented to our insurance carrier in the credentialing process.

Please print or type answers and complete a separate form for each malpractice claim reported to your malpractice insurance carrier, regardless if it is opened, closed or settled.

Physician's Name: ____

Insurance Carrier: ____

Claim filed on behalf of: ______________________________ **Age:**__________

Date of Occurrence: ____

Date of Lawsuit: ____

Your status regarding this claim: **Primary Defendant**____________
(check one) **Co-defendant**_______________

What was the patient's outcome? ______________________________________

____

What was your involvement with the patient?____________________________

____

____

Status of this claim. **Still pending** ____________ **Trial date set for**: ______________

Settled out of court: ________ **Amount of Settlement:**___________

Dismissed: _____________ **Date of Dismissal:** _____________

This malpractice claims information is required on all claims/lawsuits that have been reported to your malpractice insurance carrier. Regardless of the status or settlement amount, details are required for all suits.

To the best of my knowledge all information contained on this form is true and accurate.

______________________________ ______________________
Signature Date