

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