

**TTG Locum Tenens, Inc.  
Malpractice Claims Information Form**



**TTG Locum Tenens**

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.

This form can be completed online or printed. Upon completion please save and attach a copy to an email to [.info@toberson.com](mailto:info@toberson.com) or print and fax to 636-891-9784.

**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