Malpractice / Liability History

Applicant's name: __________________________________________________ Today's date: _______________

Please submit a form for each past or current professional liability claim or lawsuit which has been filed against you. Photocopy this page as needed. Only a legible and signed narrative which addresses all of the following details will be accepted.

1. Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. Please submit additional pages of narrative if necessary.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
Date of occurrence: ______________________ Details: ___________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

2. Date suit or claim was filed: ______________________

Name and address of insurance carrier that handled the claim: ______________________________________
________________________________________________________________________________________

3. Your status in the legal action (primary defendant, codefendant, other):

4. Current status of suit or other action:

5. Date of settlement, judgment, or dismissal:

6. If the case was settled out of court, or with a judgment, settlement amount paid on your behalf, please disclose the amount.

You must enclose a copy of final disposition of case this includes dismissals. $ ______________

I verify the information contained in this form is correct and complete to the best of my knowledge:

Signature ____________________________ Date __________________

Washington Medical Commission
P.O. Box 47866
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360-236-2730