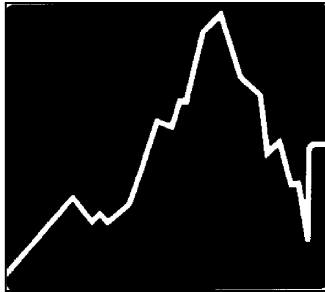


Print Name: \_\_\_\_\_



**Department of Health Professions  
Commonwealth of Virginia**

**Board of Medicine  
9960 Mayland Drive, Suite 300  
Henrico, Virginia 23233-1463**

**FAX (804) 527-4426  
(804) 367-3051**

**CLAIMS HISTORY**

If you answered "yes" to Question #10 on page three of the application, please either have your attorney submit a letter regarding malpractice suits or complete one of these forms for each case you have been involved.

**(Make additional copies of this form as needed)**

Claimant: \_\_\_\_\_

Date of Incident: \_\_\_\_\_ Date Claim Made: \_\_\_\_\_

Name of all Defendants, Persons or Entities against whom claim was made: \_\_\_\_\_

City, County and State of Suit: \_\_\_\_\_

Name and Address of Defense Attorney: \_\_\_\_\_

Settlement Amount (if any): \_\_\_\_\_ Verdict Amount: \_\_\_\_\_ Date Case Closed: \_\_\_\_\_

Current Status of Claim (indicate insurance company reserve if case is not closed): \_\_\_\_\_

Name of Involved Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Detailed Description of Claim (use reverse side if necessary): \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize any person, company, insurer, hospital or other organization to release any and all information, privileged, or in their dominion, custody, or control, regarding insurance applications by me, professional liability issued to me, any employment or personnel records involving me and any health, medical psychological or psychiatric records involving me, as well as information obtained by any attorneys who are now representing, or have in the past represented me.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date