



NORTHWEST PHYSICIANS

THE DOCTORS COMPANY

2965 Ryan Drive SE : PO Box 13400 : Salem, OR 97309-1400
(503) 371-8228 : (800) 243-3503 : Fax (503) 371-0087: www.npictdc.com

FORM A -- Supplement to Application CLAIM / INCIDENT REPORT

Please complete a section for each claim or incident for which you responded "YES" on your application. Answer in adequate detail to allow proper evaluation. Attach copies of patient's charts, operative notes or other documents as appropriate. Make additional copies of blank Form A, if necessary to provide all requested information on all claims / medical incidents.

I. 1. Name of patient: _____ Date of Birth: _____ Sex: _____

2. Incident Request for record Demand for money or services (claim) Lawsuit

3. Date of injury (medical incident): ____ / ____ / ____ Location of injury (hospital, office, etc.): _____

4. Injury or Allegation _____

5. Condition/diagnosis at time of injury _____

6. Dates/description of treatment rendered _____

7. Your involvement: Primary Defendant Co-defendant Other (describe): _____

8. Your insurance carrier _____

9. Other physicians or entities involved _____

10. Disposition of claim:
 Closed without payment Open - status: _____
 Settlement against: yourself co-defendant \$ _____
 Judgment/Verdict against: yourself co-defendant \$ _____

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I understand this information is a part of my Professional Liability Insurance Application.

Please print name: _____

Signature: _____ Date: _____