FORM V

"Yes" Response to Questions in Malpractice History/Professionalism Section

Complete this form if your response to any part of the questions in this section was "Yes." You must complete a separate Form V for each malpractice suit or claim in which a monetary payment was made on your behalf. Make additional copies as needed. Each page must carry a signature and date.

| TMB ID #: | | | |
|--|---|---|--|
| Application type: | | _ | |
| Applicant name: | | | |
| Patient's name or initials: | | _ | |
| Date suit or settled claim was | reported to insurer/self-insured phy | /sician: | |
| | this malpractice suit or claim occur | during post-graduate training? If yes, please indicate | |
| | | eported to your insurer within the 10 years prior to ed to complete the remainder of this form. | |
| In addition, we will require t | the following supporting docume | ntation for each suit or settled claim. | |
| If the claim/suit is still a letter directly to the DISCLAIMER: Please be advithat you submit the above adclaim over 10 years if deemed. | board regarding the allegations, de ised that upon review of your applic ditional documentation and complet | oresented you (or who is currently representing you) send fense, current status and/or outcome of the suit. Eation and medical malpractice history, staff may request the remainder of this form for a malpractice suit or | |
| | | | |
| | Check one): □ Malpractice Suit | □ Settled Claim | |
| Location of incident:City/ State | | Facility Name | |
| Date of disposition: | | _ | |
| Status of suit (Check one): | □ Pre-Trial Settlement | □ Post-Trial Settlement | |
| | □ Dismissed with Prejudice | □ Dismissed Without Prejudice | |
| | ☐ Judgment after Trial | □ Pending | |
| | □ Other (please specify) | | |
| Applicant's Signature | | Date | |

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| Amount paid on your behalf: | | |
|---|---|-----------------------------|
| Personal statement with a detailed summary of your necessary. Remember to sign and date each page. Plea | involvement and role in patient care se type or print statement.) | e. (Use additional paper if |
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| Patient outcome: | | |
| | | |
| Applicant's Printed Name | | |
| Applicant's Printed Name | | |
| Applicant's Signature | Date | |