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 regardless of payment and/or any 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 physician: _____

For physician applicants: Did this malpractice suit or claim occur during post-graduate training? If yes, please indicate your title and year. _____

If the malpractice suit or settled claim indicated above was reported to your insurer within the 10 years prior to the date of submission of your TMB application, you will need to complete the remainder of this form and submit the supporting documentation listed below.

If the suit/claim was reported MORE than 10 years prior to the date of submission of your TMB application, you will NOT need to complete the remainder of this form or submit the supporting documentation listed below.

Supporting Documentation:

- A copy of the plaintiff's original complaint,
- A copy of the disposition if the claim resulted in a suit,
- A Form I completed by the carrier with whom the suit/claim was been filed,
- If the claim/suit is still pending, have the attorney who represented you (or who is currently representing you) send a letter directly to the board regarding the allegations, defense, current status and/or outcome of the suit.

DISCLAIMER: Please be advised that upon review of your application and medical malpractice history, staff may request that you submit the above additional documentation and complete the remainder of this form for a malpractice suit or claim over 10 years if deemed necessary.

Date of injury: _____

Type of malpractice incident (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) _____

Amount paid on your behalf: _____

_____ _____
Applicant's Signature Date

FORM V

Personal statement with a detailed summary of your involvement and role in patient care. (Use additional paper if necessary. Remember to sign and date each page. Please type or print statement.)

Patient outcome: _____

_____
Applicant's Printed Name

_____ _____
Applicant's Signature Date