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| --- | --- |
| **Resident/Fellow Name** | Click or tap here to enter text. |
| **Birthdate** | Click or tap here to enter text. |
| **UM Program for Training** | Click or tap here to enter text. |
| **If any additional information is needed, how may we contact you?**  E-mail: Click or tap here to enter text.  Phone: Click or tap here to enter text. | |

**MALPRACTICE CLAIMS/NOI’s/LAWSUITS EXPLANATION FORM**

**(Please use a separate form for each claim/NOI/lawsuit.)**

|  |  |
| --- | --- |
| **Name of Claimant** | Click or tap here to enter text. |
| **Date of Incident** | Click to enter a date. |
| **Date of Claim/NOI** | Click to enter a date. |
| **Date of Lawsuit** | Click or tap here to enter text. |
| **Where Incident Occurred (Name of Hospital, Clinic, etc.)** | Click or tap here to enter text. |
| **Your Attorney** | Click or tap here to enter text. |
| **If Lawsuit** | Court: Click or tap here to enter text.  Title of Case: Click or tap here to enter text.  Case #: Click or tap here to enter text. |
| **What was your status?** | Sole Defendant  Co-Defendant with Click or tap here to enter text.  Other Click or tap here to enter text. |
| **Nature of Allegations** | Click or tap here to enter text. |
| **Please briefly explain your role/involvement** | Click or tap here to enter text. |
| **Current status of patient’s medical condition** | Click or tap here to enter text. |
| **Outcome** | Open/Pending  Settled; Date Settled Click to enter a date.  Closed; Date Closed Click to enter a date. |
| **Additional Comments** | Click or tap here to enter text. |

**Please send a secure e-mail with your completed form(s) to:**

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