ARIZONA MEDICAL BOARD
1740 W. Adams St. Ste. 4000 Phoenix, AZ 85007-2664
Phone: 480-551-2700 Fax: 480-551-2704

MALPRACTICE FORM

The applicant must complete this form for **each** malpractice settlement or judgment. If more than one case, please make copies of this form and return with required documents.

First Name: _____ **Last Name:** _____

Provide a detailed clinical narrative regarding each malpractice case(s). Include name of patient, age, sex, date of occurrence and location (include address). Do not omit the answers to these questions or make reference to attached documents for answers. This section must be completed with your own description that includes all of the facts requested above. *NOTE:* HIPAA regulations do not prevent you from responding and providing the requested information. Please include a separate sheet of paper if you require more room for your narrative. **Please provide a copy of the plaintiff's complaint and copy of the judgment or settlement agreement for each case.**

NARRATIVE:

1. Amount of settlement or judgment: _____ **2. Date of judgment or settlement:** _____

3. Amount of settlement or judgment attributed to you: _____

4. Has this case been investigated or reviewed by any State Medical Board? ☐ Yes ☐ No

If answer is "Yes" , **request that a letter of resolution from the State Medical Board to be sent directly to us.**

I certify that the information which I have provided is correct to the best of my knowledge.

Signature of Applicant: _____ Date: _____