

OREGON MEDICAL BOARD
1500 SW First Avenue, #620
Portland, OR 97201-5847
Phone (971) 673-2700
FAX (971) 673-2670
www.oregon.gov/omb

Monthly CLOSED MALPRACTICE CLAIMS REPORT 2008 Order Form

Name: _____

Company: _____

Address: _____

Address: _____

City/State/Zip: _____

The Monthly Closed Malpractice Claims Report contains information about **Oregon** malpractice claims that were **closed** in a particular month. Please check the boxes for the monthly reports you wish to purchase below:

- | | |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> January | <input type="checkbox"/> July |
| <input type="checkbox"/> February | <input type="checkbox"/> August |
| <input type="checkbox"/> March | <input type="checkbox"/> September |
| <input type="checkbox"/> April | <input type="checkbox"/> October |
| <input type="checkbox"/> May | <input type="checkbox"/> November |
| <input type="checkbox"/> June | <input type="checkbox"/> December |

This report is \$15.00 per month. You may purchase up to a year's worth of reports using this form. To calculate your total cost, multiply the number of reports you checked above by \$15.00.

Please indicate the number of reports desired: ____ report(s) X \$15 = \$_____

The Board will complete the above request immediately upon receipt of the required fee. If paying by check, please make your check payable to the "Oregon Medical Board." You may also purchase this report with a credit card by completing the form below.

I am requesting a previous report. I am already a monthly subscriber. I would like a past Closed Malpractice Claim report dated: _____. Since I am already a monthly subscriber, I understand there is no charge for old Closed Malpractice Claim reports.

For faster service, please return this letter with your payment. Thank you!

Jeri Richardson
Investigations Secretary

For Office Use Only Date Serviced Performed: _____ By: _____

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Credit Card Payment

Note: All payment information is confidential, Oregon Medical Board use only.

<hr/>			§ Amount
Company Name			
<hr/>			
Printed Name as it Appears on Card			
<hr/>		<hr/>	
Signature		Phone Number with Area Code	
<hr/>			
Cardholder's Mailing Address			
<hr/>			
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Credit Card Number – VISA, MASTERCARD, OR DISCOVER		Expiration Date Security Code	