Oregon Negligence/Malpractice Claim Report Form

Oregon Medical Board

1500 SW First Avenue, Suite 620 • Portland, Oregon 97201-5847

(971) 673-2700 • www.oregon.gov/omb

Per ORS 742.400, claim "reporters" are required to submit claim information to the Oregon Medical Board within 30-days of notice to them, and again when the claim is resolved, including claims closed without payment. **The form below should be completed for every open and closed claim received by the reporting entity.** This form is designed for reporters to fill out electronically. Please send the printed, completed form to the Oregon Medical Board at the address above.

Reporting Entity Information:

Initial Report ☐ Yes ☐ No | **Previous Report Closure Info.** ☐ Yes ☐ No | **Correction to Previous Report** ☐ Yes ☐ No | **Previously Reported, but Re-opened** ☐ Yes ☐ No

Reporting Entity: ____________ **NAIC #:** ________ **Claim File ID:** ____________

Contact Person: ____________ **Phone #:** ____________

Mailing address: **City:** **State:** **ZIP:**

Covered Practitioner (MD, DO, DPM, PA only):

License #: ________ Name: ____________ Date of Birth: ____________

Address: ____________ Phone: ( )

City: ____________ State: ________ Zip: ____________

Board certified (code): Specialty (code): Other spec. (code):

Injury/Incident Data:

Injured person's name: ____________ Age: ________ ☐ M ☐ F

Date of injury: ________ Date reported to insurer: ________ If re-opened, date re-opened: ________

Is Claim Court-Filed? ☐ Yes ☐ No If Yes, Date Filed in Court: ____________

Place where injury occurred (code): ________ City: ________ State: ________ Zip: ________

Name of institution (if injury occurred in institution): ____________ Location in institution (code): ________

Total defendants involved in claim: ________ Derivative claim (code): ____________

Plaintiff attorney's name: ____________ Address: ____________

City: ____________ State: ____________ Zip: ____________

Severity of injury (code): ________ Misadventures in procedures (code): ________ Misadventures in diagnosis (code): ________

Others contributing to injury (code): ________ Associated issues (code): ________ Coverage (code): ________

Companion claim file identification:

Allegations and reasons for claim. State patient's actual, original, abnormal condition and any material diagnosis, procedure, planning error, medical injury or other allegation: *(Please be as detailed as possible)*

Closure Data:

Closure date: ________ Claim disposition (code): ________ Settlement (code): ________

Court (code): ________ Binding arbitration (code): ________ Review panel (code): ________

	Economic	Non-economic	Punitive	Unspecific
Indemnity insurer paid on behalf of defendant:	$	$	$	$
Other indemnity paid by/on behalf of defendant:	$	$	$	$
Indemnity paid by all parties (for all defendants):	$	**Additional Comments:**		
Loss adjustment expense paid to defense counsel:	$			
All other allocated loss adjustment expenses paid:	$			

Date Board Received Claim: ____________