

Washington Medical Commission
P.O. Box 47866
Olympia, WA 98504-7866
360-236-2750

Malpractice / Liability History

Applicant's name: _____ Today's date: _____

Please submit a form for each past or current professional liability claim or lawsuit which has been filed against you. Photocopy this page as needed. Only a legible and signed narrative which addresses all of the following details will be accepted.

1. Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. Please submit additional pages of narrative if necessary.

Date of occurrence: _____ Details: _____

2. Date suit or claim was filed: _____

Name and address of insurance carrier that handled the claim: _____

3. Your status in the legal action (primary defendant, codefendant, other):
4. Current status of suit or other action:
5. Date of settlement, judgment, or dismissal:
6. If the case was settled out of court, or with a judgment, settlement amount paid on your behalf, please disclose the amount.

You must enclose a copy of final disposition of case this includes dismissals. \$ _____

I verify the information contained in this form is correct and complete to the best of my knowledge:

Signature _____ Date _____