

Applicant: If you answered affirmatively to questions #12 and #12a on the Application for Licensure, complete both the top portion and release area of this form; have this form notarized, and submit this form to all malpractice carriers verifying coverage **within the past 10 years**. Copies of this form may be used if you have more than one malpractice carrier.

FORM 4

MALPRACTICE CLAIM VERIFICATION REQUEST

Insurance Carrier Information:

Name of Insured Genetic Counselor: _____

Name of Insurance Company: _____

Address: _____

Phone: _____ Fax: _____

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To be completed by verifying agency only

Policy Number: _____

Policy Period From: _____ To: _____

**Please provide a loss history report with this verification.

Claims Experience:

Has this Genetic Counselor had a settlement paid on his/her behalf? _____ Yes _____ No

If "yes", please provide the following information:

<i>Occurrence Date</i>	<i>Status</i>	<i>Date Closed</i>	<i>Indemnity Amount</i>
_____	_____	_____	_____

Description of Claim: _____

Insurance Carrier Agent:

Print Name and Title

Signature of Agent

Telephone

Email address

Please mail completed form to:
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the State of Nevada.

Genetic Counselor (applicant) signature and date

Subscribed and sworn to before me this _____ day of _____, 2_____,

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____ City _____ State _____

Signature and Seal of Notary Public