**Applicant:** *If you answered affirmatively in your application to being named in a malpractice case and a settlement has been paid on your behalf, 1) complete both the top portion and Release area of this form;2) have this form notarized, and 3) submit this form to all malpractice carriers verifying coverage within the past 10 years. Once notarized, 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 Physician: _____

Name of Insurance Company: _____
Address: _____
_____
_____

Phone: _____ Fax: _____

---

**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 Physician had a settlement paid on his/her behalf? _____Yes _____No

If "Yes", please provide the following information:

| *Occurrence Date* | *Status* | *Date Closed* | *Indemnity Amount* $ |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

*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
*or email to* nsbme@medboard.nv.gov

**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.

_____
*Medical Doctor (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*

**Malpractice Insurance Carrier:** *If you have questions, you may contact the Nevada State Board of Medical Examiners at (775) 688-2559.*