***Applicant:*** *If you answered affirmatively to being named in a malpractice case or a settlement has been payed on your behalf, 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 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

**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
______________________________, 20_____________,

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 Board at (775) 688-2559.*