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 Practitioner: _____

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 Practitioner of Respiratory Care 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 send 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.

_____
Practitioner of Respiratory Care (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.*