California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to		he	erein, this Healthcare Organiza	ation	
which you were named a party in not any payment was made on yo avoid delay in expediting your app B prior to completing, and comple	th pending, settled or otherwise con the past seven (7) years, whether to bur behalf by any insurer, company, plication. If there is more than one pate a separate form for each lawsuit there are no pending/settled of	he lawsuit or arbitration is hospital or other entity. professional liability laws	s pending, settled or otherwise All questions must be answere uit or arbitration action, please	concluded, and whether or ed completely in order to	
I. Practioner Identifyin		wiinis io report (un	a sign occom to access).		
Last Name:		First Name:		Middle:	
II. Case Information					
Patient's Name:	Patient	Gender Male (Female Patient D	DOB:	
City, County, State where lawsuit	filed: Court C	ase namber, ii known.	Date of alleged incident servin basis for the lawsuit/ arbitration:	g as Date suit filed:	
Location of incident: Hospital My Office Other doctor's office Surgery Center Other (specify)					
Relationship to patient (Attending Allegation	physician, Surgeon, Assistant, Co	nsultant, etc.)			
organization providing coverage/d	ny or other liability protection compa lefense of the lawsuit or arbitration ame, contact person, phone numbe	action? () Yes		other liability protection	
If you would like us to contact you document to your attorney as this	r attorney regarding any of the abo will serve as your authorization:	ve, please provide attorn	ey(s) name(s) and phone num	ber(s). Please fax this	
Name:		Telephone Number:	Fax N	Number:	

III. Status of Lawsuit/Arbitration (check one)				
Lawsuit/arbitration still ongoing, unresolved.				
Judgment rendered and payment was made on my beha	lf. Amount paid on my behalf:			
Judgment rendered and I was found not liable.	, another part of the part of			
Lawsuit/arbitration settled and payment made on my beh	alf. Amount paid on my behalf:			
Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.				
Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.				
Please include: 1. Condition and diagnosis at the time of incident, 2. Dates and description of treatment rendered, and 3. Condition of patient subsequent to treatment.				
SUMMARY				
I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".				
APPLICANT SIGNATURE (Stamp is Not Acceptable)	PRINTED NAME DATE			