

UA

UNIFORM APPLICATION  
FOR PHYSICIAN  
STATE LICENSURE

### Affidavit and Authorization for Release of Information

This form should be sent to the state board you are applying to, NOT to FSMB.

**Applicant:**

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in the square below.

Sign this form with attached photo in the presence of a notary public.

Send the notarized form to the board you are applying to for licensure.

**DO NOT SEND THIS FORM TO FSMB.**

Doing so will cause a delay with your state board application.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

**Applicant Photograph**

Please see the instructions above.

\_\_\_\_\_  
Applicant's signature (must be signed in the presence of a notary)

\_\_\_\_\_  
Applicant's printed last name

\_\_\_\_\_  
Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

\_\_\_\_\_  
Date of signature (must correspond to date of notarization)

**Notary**

State of \_\_\_\_\_, County of \_\_\_\_\_

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public Signature: \_\_\_\_\_

(NOTARY PUBLIC SEAL)

My Notary Commission Expires: \_\_\_\_\_

**UA**UNIFORM APPLICATION  
FOR PHYSICIAN  
STATE LICENSURE**Licensure Verification (UA Form #1)**

This form should be sent to each board with which you have ever held a license.

**Applicants:**

Complete Section 1. In the Authorization area, list the board that needs to verify your license as well as your license number. Type or print legibly.

Send this form and any required fee for this verification to the authorizing board.

Copy this form for multiple licenses.

**Section 1: Applicant Information**

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security number\*: \_\_\_\_\_

\*The social security number is to be used for purposes of identification only and may not be used for any other reason.

In listing the Board information below, please reference [http://www.fsmb.org/directory\\_smb.html](http://www.fsmb.org/directory_smb.html).

Name of Board applying to: \_\_\_\_\_

Board address: \_\_\_\_\_

Board city/state/zip code: \_\_\_\_\_

**Authorization:** I am applying for a license to practice medicine. The Board I am applying to requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of \_\_\_\_\_ to provide any and all information pertaining to license number \_\_\_\_\_ to the Board listed above.

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_

**State Licensing Board  
or Canadian Province:**

Please complete Section 2. Send this form to the board at the address listed in Section 1.

**Section 2: Licensure Verification**Name of Licensee: \_\_\_\_\_  
Last First Middle Suffix

License type: \_\_\_\_\_ License number: \_\_\_\_\_

Issue date: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Is this license current?  Yes  No If not current, please explain: \_\_\_\_\_

1. Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?  Yes  No  Cannot answer under state law

If yes, please explain: \_\_\_\_\_

2. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state?  
 Yes  No  Cannot answer under state law

If yes, please explain: \_\_\_\_\_

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

AFFIX BOARD SEAL HERE

(If no seal is available, this form must be notarized.)

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Email: \_\_\_\_\_



## Medical School Verification (UA Form #2)

This form should be sent to the current Dean of your medical school.

**Applicants not using  
FCVS:**

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form and a copy of your medical school diploma to the current Dean of your medical school.

Copy this form for multiple medical schools.

**Section 1: Applicant Information**

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Name if different when diploma awarded: \_\_\_\_\_

Name of medical school: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security number\*: \_\_\_\_\_

*\*The social security number is to be used for purposes of identification only and may not be used for any other reason.*

In listing the Board information below, please reference [http://www.fsmb.org/directory\\_smb.html](http://www.fsmb.org/directory_smb.html).

Name of Board applying to: \_\_\_\_\_

Board address: \_\_\_\_\_

Board city/state/zip code: \_\_\_\_\_

**Waiver for Release of Information:** I authorize the medical school listed above to provide any and all information pertaining to my medical education at that institution to the Board listed above. I request that the Dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached), then return this form, the sealed diploma, and a copy of my official transcripts to the Board listed above at the given address.

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Dean or  
Designated Official:**

Please complete Section 2 of this form, certify the enclosed copy of the above named applicant's diploma by placing your school seal on it, provide an official copy of the transcripts of the above named physician, and send these documents with this form and any attachments to the state board listed in Section 1.

If transcripts are not in English, an original, certified, and official English translation is required.

**Section 2: Medical School Verification**

Medical school name: \_\_\_\_\_

School name if different when the above applicant attended: \_\_\_\_\_

Medical school address (including city, state or province, zip code, and country as applicable):  
\_\_\_\_\_  
\_\_\_\_\_

Hours of undergraduate education required for admission into your school: \_\_\_\_\_

Total weeks of education applicant attended your school: \_\_\_\_\_

Applicant's attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Graduation date: \_\_\_\_\_ Degree: \_\_\_\_\_  
(indicate N/A if not applicable) (indicate N/A if not applicable)

The questions on the following page apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response(s) and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation. Attach additional pages as necessary.

Applicant Name: \_\_\_\_\_

1. Do the official records for this individual reflect (an) interruption(s) or extension(s) in his/her medical education? Yes  No

If yes, please select the reason(s), indicate the dates of the interruption(s) or extension(s), and indicate whether the interruption(s)/extension(s) was/were approved or unapproved.

	From Month/Year	To Month/Year	Approved	Unapproved
<input type="checkbox"/> Personal/Family	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Academic remediation	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Health	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Financial	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Participation in joint degree program (e.g., MD/PhD)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Participation in non-research special study (e.g., fellowship, international experience)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Yes  No

If yes, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation, and attach documentation/information of the circumstances and outcome(s).

	From Month/Year	To Month/Year
<input type="checkbox"/> Academic probation	_____	_____
<input type="checkbox"/> Probation for unprofessional conduct/behavioral reasons	_____	_____
<input type="checkbox"/> Probation for other reason(s) (please specify):	_____	_____

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Yes  No

If yes, please attach documentation/information of the circumstances and outcome(s).

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Yes  No

If yes, please attach documentation/information of the circumstances and outcome(s).

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes  No

If yes, please attach documentation/information of the nature of the limitations or special requirements.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Email: \_\_\_\_\_

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)



### Postgraduate Training Verification (UA Form #3)

This form should be sent to the Program Director of your postgraduate training program.

**Applicants not using FCVS:**

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to the current Program Director of your postgraduate training program.

Copy this form for multiple training programs.

**Section 1: Applicant Information**

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Name if different when diploma awarded: \_\_\_\_\_

Name of postgraduate training program: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security number\*: \_\_\_\_\_

*\*The social security number is to be used for purposes of identification only and may not be used for any other reason.*

**In listing the Board information below, please reference [http://www.fsmb.org/directory\\_smb.html](http://www.fsmb.org/directory_smb.html).**

Name of Board applying to: \_\_\_\_\_

Board address: \_\_\_\_\_

Board city/state/zip code: \_\_\_\_\_

**Waiver for Release of Information:** I authorize the postgraduate training program listed above to provide any and all information pertaining to my medical education at that institution to the Board listed above. I request that the Program Director or designated official complete Section 2 of this form and send it to the Board listed above at the given address.

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Program Director or Designated Official:**

Please complete Section 2. Report incomplete years separately from those that were completed successfully. Report each Internship, Residency, and Fellowship separately.

Use one section per specialty/subspecialty and provide a schedule of rotations if the specialty/subspecialty is rotating/transitional.

Make copies and attach additional pages if necessary.

Send this form to the board listed in Section 1 with any added documentation, if applicable.

**Section 2: Postgraduate Training Verification**

Institution name: \_\_\_\_\_

Institution address: \_\_\_\_\_

Institution city / state or province / zip code: \_\_\_\_\_

Affiliated medical school name: \_\_\_\_\_

Institution / school name if different when the applicant attended: \_\_\_\_\_

Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  Internship  Residency  Fellowship

Research  Chief Residency  Other: \_\_\_\_\_

Specialty/Subspecialty: \_\_\_\_\_

Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Successfully completed\*?  Yes  No  In progress with expected completion date of \_\_\_\_\_

*\*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  
 RCPSA  APPAP  None of these

Applicant Name: \_\_\_\_\_

Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  Internship  Residency  Fellowship  
 Research  Chief Residency  Other: \_\_\_\_\_

Specialty/Subspecialty: \_\_\_\_\_

Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Successfully completed\*?  Yes  No  In progress with expected completion date of \_\_\_\_\_

*\*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  
 RCPSC  APPAP  None of these

Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  Internship  Residency  Fellowship  
 Research  Chief Residency  Other: \_\_\_\_\_

Specialty/Subspecialty: \_\_\_\_\_

Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Successfully completed\*?  Yes  No  In progress with expected completion date of \_\_\_\_\_

*\*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  
 RCPSC  APPAP  None of these

**Unusual Circumstances**

- 1. Did this individual ever take a leave of absence or break from his/her training?  Yes  No
- 2. Was this individual ever placed on probation?  Yes  No
- 3. Was this individual ever disciplined or placed under investigation?  Yes  No
- 4. Were any negative reports for behavioral reasons ever filed by instructors?  Yes  No
- 5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason?  Yes  No

Please explain any "Yes" response on an additional page or in the blank sidebar area above.

**I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.**

Signature: \_\_\_\_\_  
Print name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_  
Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_  
Email: \_\_\_\_\_

AFFIX INSTITUTIONAL SEAL HERE  
(If no seal is available, this form must be notarized.)



### Fifth Pathway Verification (UA Form #4)

This form should be sent to your Fifth Pathway Program Director.

**Applicants not using  
FCVS:**

Complete Section 1  
and fill in your name  
at the top of page 2.  
Type or print legibly.

Send this form to your  
Fifth Pathway  
Program Director.

**Section 1: Applicant Information**

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Name if different when certificate awarded: \_\_\_\_\_

Name of medical school: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security number\*: \_\_\_\_\_

*\*The social security number is to be used for purposes of identification only and may not be used for any other reason.*

In listing the Board information below, please reference [http://www.fsmb.org/directory\\_smb.html](http://www.fsmb.org/directory_smb.html).

Name of Board applying to: \_\_\_\_\_

Board address: \_\_\_\_\_

Board city/state/zip code: \_\_\_\_\_

**Waiver for Release of Information:** I authorize the Program Director or designated official of the Fifth Pathway program to provide any and all information pertaining to my medical education at that institution to the Board listed above. I request that the Program Director or designated official complete Section 2 of this form and send it to the Board listed above at the given address.

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Program Director or  
Designated Official:**

Please complete all of  
Section 2. Send this  
form to the board  
listed in Section 1  
with any added  
documentation, if  
applicable.

**Section 2: Fifth Pathway Verification**

Institution name: \_\_\_\_\_

Institution address: \_\_\_\_\_

Institution city / state or province / zip code: \_\_\_\_\_

Institution / school name if different when the applicant attended: \_\_\_\_\_

Enrollment dates: From \_\_\_\_\_ to \_\_\_\_\_

Completed?  Yes. Certification date: \_\_\_\_\_

No. Withdrawal date: \_\_\_\_\_

No. Dismissal date: \_\_\_\_\_

In progress. Expected completion date: \_\_\_\_\_

If the applicant withdrew or was dismissed, please explain in the space below. Attach additional information if needed.

Applicant Name: \_\_\_\_\_

Type of Clinical Rotation	From	To	Number of Weeks Credit
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Unusual Circumstances**

1. Did this individual ever take a leave of absence or break from his/her training?  Yes  No
2. Was this individual ever placed on probation?  Yes  No
3. Was this individual ever disciplined or placed under investigation?  Yes  No
4. Were any negative reports for behavioral reasons ever filed by instructors?  Yes  No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason?  Yes  No

Please explain any "Yes" response in the blank space below. Attach additional information if needed.

**I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.**

AFFIX INSTITUTIONAL SEAL HERE  
(If no seal is available, this form must be notarized.)

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Email: \_\_\_\_\_

Addendum 4A

Reference Form

Substitute forms are not acceptable. This form may be duplicated as needed.

This form is to be completed by the individual providing the reference. Please return the completed form directly to the Board at:

Vermont Department of Health
Board of Medical Practice
108 Cherry Street, P.O. Box 70
Burlington, VT 05401

Name of Applicant: \_\_\_\_\_

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr. \_\_\_\_\_ was at \_\_\_\_\_
From \_\_\_\_\_ to \_\_\_\_\_. During that time, he/she was (List status in the Institution): \_\_\_\_\_

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

Table with 5 columns: Category, Poor, Fair, Average, Above Average. Rows include: Basic medical knowledge, Professional judgment, Sense of responsibility, Moral character/ethical conduct, Competence and skill, Cooperativeness, ability to work with others, History & physical exam taking, Record keeping, Case presentations, Patient management, Physician-Patient Relationship, Competence in being able to communicate in reading, writing and speaking the English language, Participation in Medical Staff Affairs.

Name of Applicant: \_\_\_\_\_

How long have you known the applicant and in what capacity? \_\_\_\_\_

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.) \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you know of any suspension, restriction, or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you know of a failure to complete a residency training program(s)? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does the applicant call upon consults when needed? \_\_\_\_\_ Yes \_\_\_\_\_ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluation this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

- \_\_\_\_\_ Close personal observation
- \_\_\_\_\_ General impression
- \_\_\_\_\_ A composite of faculty/staff evaluations
- \_\_\_\_\_ Other - Specify: \_\_\_\_\_

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend \_\_\_\_\_ for licensure in Vermont.  
Name of Physician

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print or Type Name and Title: \_\_\_\_\_

**A. Judgments**

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases; complete the below information and provide copies of papers fully documenting these matters.

Judgment       Arbitration

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(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against You)
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If necessary, please use an additional sheet and check this box: .....

**B. Settlements**

Please provide a description of all pending settlements and settlements of medical malpractice claims against you. Please complete the below information and provide copies of papers fully documenting these matters.

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(Date)	(Court)	(State)	(Amount Assessed Against You)
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If necessary, please use an additional sheet and check this box: .....

**Medical Malpractice Claim**

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer \_\_\_\_\_

Claimant Name \_\_\_\_\_

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:

1. Patient's condition at point of your involvement;
2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

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If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

\_\_\_\_\_

Your role (circle one):

- |                           |                                     |
|---------------------------|-------------------------------------|
| 01 Anesthesiologist       | 11 PGY 4                            |
| 02 Primary Care Physician | 12 PGY 5                            |
| 03 Referring Physician    | 13 PGY 6                            |
| 04 Attending Physician    | 14 PGY 7                            |
| 05 Consultant Specialist  | 15 Workman's Compensation Evaluator |
| 06 Surgeon                | 16 Court Psychiatrist               |
| 07 Fellow                 | 17 On-Call Physician                |
| 08 PGY 1                  | 18 Group Practitioner/Partner       |
| 09 PGY 2                  | 19 Other: Specify _____             |
| 10 PGY 3                  | 20 Unknown                          |

Your Legal Representative in this matter (include name, address and telephone number)

Name \_\_\_\_\_

Firm \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_

**Indicate Decision, Appeal, Settlement, Dismissal:**

If a Court or Arbitration Panel heard your case, indicate the following:

Court \_\_\_\_\_

Court's location \_\_\_\_\_

Docket number \_\_\_\_\_

Date the action was filed \_\_\_\_\_

Decision determined by (check one): \_\_\_\_\_ Judge \_\_\_\_\_ Jury \_\_\_\_\_ Arbitration Panel

Decision: \_\_\_\_\_ Award: \_\_\_\_\_

If your case was appealed, indicate the following: Date appeal filed (month, day, year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date appeal decided: (month, day, year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

If your case was settled, indicate the following:

Settlement amount paid on your behalf: \_\_\_\_\_

Total settlement amount: \_\_\_\_\_

Date of settlement: (month, day, year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ Case dismissed against you \_\_\_\_\_ Against all defendants

**Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.**

Additional information, if any: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_