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Commonwealth of Massachusetts Board of Registration in Medicine 200 Harvard Mill Square, Ste 330

Wakefield, MA 01880

MA PROFESSIONAL LIABILITY INSURANCE REPORT OF CLOSED CLAIM - PLICC

Report Date: / /

Check here if this form amends a previously filed Form PLICC

# Reporting Insurer

Name of Insurer:

Individual to contact, if necessary: Telephone #:

# Physician Information

Name:

Office Address:

Zip Code

Policy #:

Massachusetts Medical License #:

# Claim Information

Date When Claim Arose (Incident Date): / / [to / / ]

Date Claim Closed: / /

Incident Place Code (Circle one.):

|  |  |  |
| --- | --- | --- |
| 01 Emergency Room | 02 Labor/Delivery | 03 Laboratory/X-Ray/Testing |
| 04 Operating Room | 05 Outpatient | 06 Patient Room |
| 07 Hospital-Other | 08 Hospital-Unknown | 09 HMO |
| 10 Clinic | 11 Nursing Home | 12 Physician's Office |
| 13 Walk-In Center | 16 ICU | 14 Other:  |

Name of Facility (if applicable):

|  |  |
| --- | --- |
| Physician's Role (Circle one.): |  |
| 01 Anesthesiologist | 08 PGY 7 | 02 Primary Care Physician |
| 03 Referring Physician | 09 PGY 6 | 04 Attending Physician |
| 05 Consultant Specialist | 10 PGY 5 | 06 Surgeon |
| 07 Fellow | 11 PGY 4 | 22 Acupuncturist |
| 23 Administrator/Supervisor | 12 PGY 3 | 24 Group Practitioner/Partner |
| 26 On-Call Physician | 13 PGY 2 | 27 Workmen's Comp Evaluator |
| 28 Court Psychiatrist | 14 PGY 1 | 98 Other:  |

Nature and Substance of Claim (Summarize; provide up to 8 basis codes from the attached table.):

Basis Code: Basis Code: Basis Code: Basis Code:

Basis Code: Basis Code: Basis Code: Basis Code:

Was a lawsuit filed in relation to this claim (Y\*/N)? :

\*If yes, supply the following information:

Docket #:

Case Name:

 Check here if a trial was held before a judge only (no jury).

|  |  |
| --- | --- |
| Venue (Circle one.): |  |
| 01 Barnstable | 02 Berkshire | 03 Bristol | 04 Dukes | 05 Essex |
| 06 Franklin | 07 Hampden | 08 Hampshire | 09 Middlesex | 10 Nantucket |
| 11 Norfolk99 Out of State | 12 Plymouth | 13 Suffolk | 14 Worcester | 50 Federal |

Final Disposition of Claim (Check as many as apply; indicate amount of judgment or settlement below, if applicable.):

 Defense Verdict Lack of Prosecution

 Plaintiff Verdict Summary Judgment for Defense

 Appeal by Defense Summary Judgment for Plaintiff

 Appeal by Plaintiff Settled

 Voluntary Dismissal Structured Settlement

 Settled by Other Defendant Other (Explain)

Total Award/Judgment/Settlement\*: $ , ,

Interest on Award/Judgment/Settlement: $ , ,

Amount Allocated to Physician: $ , ,

Interest on Contribution: $ , ,

\*If Structured Settlement/Payment:

Present Value: $ , ,

Amount per Year: $ , ,

Number of Years:

Other Details:

1. Claimant/Plaintiff

Claimant/Plaintiff Name:

Address:

Zip Code

Date of Birth: / /

1. Additional Defendants

Name:

License #:

Office Address:

Zip Code

Name:

License #:

Office Address:

Zip Code

Name:

License #:

Office Address:

 - Zip Code: -

Name:

License #:

Office Address:

Zip Code