**Commonwealth of Massachusetts Board of Registration in Medicine**

**178 Albion Street, Suite 330 – Wakefield, MA 01880**

**Telephone: (781) 876-8210 Fax: (781) 876-8383**

[**www.mass.gov/massmedboard**](http://www.mass.gov/massmedboard)

|  |
| --- |
| **LIABILITY CARRIER REQUEST FORM** |
| **Applicant Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **APPLICANT INSTRUCTIONS**: **Print name above**. In **chronological order**, list your liability carriers covering the **past 10 years that you have held a full license in the U.S. or Canada**. Only include liability carriers from postgraduate training if it was within the past 10 years and you held a full license at that time. Send a copy of this form to each carrier in order to request a claims history report. Send the original form to the Board with your application. This form is not required if you have never held a full license in the U.S. or Canada.  |
| **Liability Carrier** |  |
| **Dates of Coverage** | From: **\_\_\_\_\_ \_\_\_\_\_\_** To: **\_\_\_\_\_ \_\_\_\_\_\_** | **Policy Number** |  |
|  |
| **Liability Carrier** |  |
| **Dates of Coverage** | From: **\_\_\_\_\_ \_\_\_\_\_\_** To: **\_\_\_\_\_ \_\_\_\_\_\_** | **Policy Number** |  |
|  |
| **Liability Carrier** |  |
| **Dates of Coverage** | From: **\_\_\_\_\_ \_\_\_\_\_\_** To: **\_\_\_\_\_ \_\_\_\_\_\_** | **Policy Number** |  |
|  |
| **Liability Carrier** |  |
| **Dates of Coverage** | From: **\_\_\_\_\_ \_\_\_\_\_\_** To: **\_\_\_\_\_ \_\_\_\_\_\_** | **Policy Number** |  |
|  |
| **Liability Carrier** |  |
| **Dates of Coverage** | From: **\_\_\_\_\_ \_\_\_\_\_\_** To: **\_\_\_\_\_ \_\_\_\_\_\_** | **Policy Number** |  |
| **LIABILITY CARRIER INSTRUCTIONS**: Please provide the following documentation directly to the Board at the above listed mailing address or via email at: malpractice.reports@MassMail.State.MA.US. If sending documents via email, you must include the physician’s name in the subject line of the email. |
| **Claims History Report/Loss Run Report:** Please provide a claims history report on letterhead, which includes:1. Policy number
2. Dates of policy coverage;
3. If your company’s name has changed, please provide any former company names.
4. Whether the applicant has any claims history;
5. If the applicant has a claims history, please include:
	1. the name/initials of the claimant(s);
	2. nature and date of claim(s);
	3. whether the claim is pending or closed. If closed, final disposition; and
	4. amounts paid on the applicant’s behalf, if any.

**Additional Claim Documentation:** If the applicant has a claims history, please provide copies of the following:1. Complaint, notice of intent to file a claim, or other claim letter; and
2. Final judgment, settlement and release, or other final disposition of each claim.
 |