



Oregon Negligence/Malpractice Claim Report Form
 Oregon Board of Chiropractic Examiners
 3218 Pringle Road SE # 150 • Salem, Oregon 97302-6311
 (503) 378-5816 • www.oregon.gov/OBCE

Per ORS 742.400 as amended by HB 2240, 2009 Oregon Legislature, claim "reporters" (chiropractic malpractice insurers) are required to submit claim information to the Oregon Board of Chiropractic Examiners within 30-days of notice to them, and again when the claim is resolved, including claims closed without payment. **The form below should be completed for every claim received by the reporting entity.** This form is designed for reporters to fill out electronically. Please send the printed, completed form to Oregon Board of Chiropractic Examiners, Attn. Cass Skinner, Executive Director, at the address above.

Reporting Entity Information:

Reporting Entity: _____ NAIC #: _____ Claim File ID: _____
 Contact Person: _____ Phone #: _____
 Mailing address: _____ City: _____ State: _____ ZIP: _____

Covered Practitioner (Chiropractic Physician only):

License #: _____ Name: _____ Date of Birth: _____
 Address: _____ Phone: _____
 City: _____ State: _____ Zip: _____
 Board certified (code): _____ Specialty (code): _____ Other spec. (code): _____

Injury/Incident Data:

Injured person's name: _____ Age: _____ M F
 Date of injury: _____ Date reported to insurer: _____ If re-opened, date re-opened: _____
Is Claim Court-Filed? Yes No **If Yes, Date Filed in Court:** _____
 Place where injury occurred (code): _____ City: _____ State: _____ Zip: _____
 Name of clinic (if injury occurred in clinic): _____
 Total defendants involved in claim: _____ Derivative claim (code): _____
 Plaintiff attorney's name: _____ Address: _____
 City: _____ State: _____ Zip: _____
 Severity of injury (code): _____ Misadventures in procedures (code): _____ Misadventures in diagnosis (code): _____
 Others contributing to injury (code): _____ Associated issues (code): _____ Coverage (code): _____
 Companion claim file identification: _____

Allegations and reasons for claim. State patient's actual, original, abnormal condition and any material diagnosis, procedure, planning error, medical injury or other allegation: (Please be as detailed as possible, attach page if needed.)

Closure Data:

Closure date: _____ Claim disposition (code): _____ Settlement (code): _____
 Court (code): _____ Binding arbitration (code): _____ Review panel (code): _____

	Economic	Non-economic	Punitive	Unspecific
Indemnity insurer paid on behalf of defendant:	\$	\$	\$	\$
Other indemnity paid by/on behalf of defendant:	\$	\$	\$	\$
Indemnity paid by all parties (for all defendants):	\$ Additional Comments:			
Loss adjustment expense paid to defense counsel:	\$			
All other allocated loss adjustment expenses paid:	\$			

Date Board Received Claim: _____