

OREGON MEDICAL BOARD
1500 SW First Avenue, #620
Portland, OR 97201-5847
Phone (971) 673-2700
www.oregon.gov/omb

MALPRACTICE / MEDICAL PROFESSIONAL CLAIMS INFORMATION

Applicant Name: _____
(Please Type or Print Legibly)

Furnish information on separate sheet for each malpractice claim.
Make copies of this form if necessary. Print or write legibly.

NAME OF PATIENT:

DATE OF INCIDENT:

LOCATION (HOSP, ETC.):

ALLEGATION:

CONDITION / DIAGNOSIS
AT TIME OF INCIDENT:

DESCRIPTION OF
MEDICAL TREATMENT
RENDERED:

CONDITION OF PATIENT
SUBSEQUENT TO
TREATMENT:

DISPOSITION OF CLAIM:
(Include settlement amount)

DISPOSITION BY
MEDICAL BOARD
IF APPLICABLE: