



Oregon Negligence/Malpractice Claim Report Form
Oregon Board of Optometry
1500 Liberty Street SE, Suite 210 • Salem, Oregon 97302
(971) 701-1194 Optometry.Board@obo.oregon.gov Fax: 503-914-5142

Per ORS 742.400, claim "reporters" are required to submit claim information to the Oregon Board of Optometry 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 the Oregon Board of Optometry at the address above.

Reporting Entity Information:

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

Covered Practitioner (O.D. 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 institution (if injury occurred in institution): _____ Location in institution (code): _____
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)

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:	\$			