Oregon Negligence/Malpractice Claim Report Form

Oregon Board of Optometry

1500 Liberty Street SE, Suite 210 • Salem, Oregon 97302
(503) 399-0662 • www.oregon.gov/obo • shelley.g.sneed@oregon.gov

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:	$			

Date Board Received Claim: _____