



**Oregon Negligence/Malpractice Claim Report Form**  
**Oregon Board of Optometry**  
 1500 Liberty Street SE, Suite 210 • Salem, Oregon 97302  
 (971) 701-1194 Optometry.Board@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:	\$			