

**SUPPLEMENTAL REPORT FORM**

AS INDICATED IN QUESTION 5H OF THE APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE, THE FOLLOWING INFORMATION IS REQUIRED. COMPLETE A SEPARATE FORM FOR EACH INCIDENT/CLAIM OR SUIT REPORTED.

ONE OF THESE FORMS MUST BE COMPLETED FOR EACH LIABILITY, PEER REVIEW OR STATE BOARD COMPLAINT, CLAIM OR INCIDENT REGARDLESS OF THE DISPOSITION OF THE COMPLAINT, CLAIM OR INCIDENT.

**PLEASE COPY THIS FORM IF YOU NEED TO REPORT MULTIPLE INCIDENTS/CLAIMS OR COMPLAINTS IF YOU HAVE HAD THEM.**

**IF NO INCIDENT/CLAIM OR SUIT, PLEASE INDICATE NONE, THEN DATE AND SIGN BELOW.**

1. Name, age and sex of patient \_\_\_\_\_

2. Date of first examination \_\_\_\_\_

3. Dental condition and diagnosis at above date \_\_\_\_\_

\_\_\_\_\_

4. Dates of treatment in question given; and nature of same \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Date of incident/claim, and allegations made against you \_\_\_\_\_

\_\_\_\_\_

6. Disposition of the incident/claim, amount of judgement or settlement \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. What insurance company, if any, was involved \_\_\_\_\_

8. Subsequent condition of health of patient \_\_\_\_\_

\_\_\_\_\_

9. Name of other doctors, if any, involved in the incident/claim or suit \_\_\_\_\_

\_\_\_\_\_

10. To whom may we refer for further information about the claim/suit \_\_\_\_\_

\_\_\_\_\_

**X** \_\_\_\_\_

Date Completed    Signature

**X** \_\_\_\_\_