

District of Columbia Medical Liability Captive

INCIDENT/CLAIM INFORMATION FORM

PLEASE COMPLETE ALL FIELDS – IF NOT APPLICABLE, WRITE “N/A”

You must complete this form with respect to any incident, potential claim, or suit against you (attach all supplemental information necessary)

1.	Healthcare provider's name:		
	ABC Free Medical Clinic		
2.	Patient's/Claimant's name:	Age:	Gender:
	Marietta Simmons	57	Female
3.	Patient's/Claimant's physical condition and diagnosis at time of the alleged incident:	Date of Incident:	
	Patient claimed loss of sight after receiving blood pressure medication	4/8/2007	
		Date incident is reported:	
4.	Description of treatment rendered:	5/16/07	
	Medication was examined and corrected for adequate dosage levels		
5.	Specific occurrence from which alleged incident resulted:		
6.	Allegations made against you (state injury or damages alleged):		
	Negligence due to rendering incorrect amounts of the wrong medication		
7.	Subsequent condition or health of patient:		
	Patient's eye sight is improving as the previous medication clears from the blood stream		

I hereby authorize release to the District of Columbia Medical Liability Captive and its agents all information concerning the above incident, claim or suit, including information possessed by third parties, such as insurance carriers, their adjusting firms, and attorneys. A photocopy of this authorization shall be considered as effective and as valid as the original.

			12/17/07	
	Healthcare Provider's Signature		Date of Signature	
	Dr. Joseph Gates			
	Print or Type Healthcare Provider's Name			