

YALE-NEW HAVEN HOSPITAL

CLAIM/SUIT REPORT

NAME: _____

DATE: _____

Please complete a form for each claim/suit received in the past ten (10) years. All sections must be completed in order for your application for credentialing/re-credentialing to be processed. The form must contain information that is current and be dated within 90 days of re-credentialing.

1. Type of Action

Suit Notice of claim from attorney or patient/guardian

Date claim made or suit filed: _____

2. Current Status

Pending Settled Plaintiff Verdict Defendant Verdict

Withdrawn With no Payment Other _____

If settled or plaintiff verdict:

Date of Settlement/Judgement: _____ Amount of Settlement/Judgement _____

National Practitioner DataBank Report Filed? Yes No

3. Malpractice Carrier Name: _____

4. Date(s) of Occurrence: From: _____ To: _____

From: _____ To: _____

5. Standing in Case

Sole Defendant

Primary Defendant; Total number of Co-Defendants _____ (indicate number)

Co-Defendant; Total number of Defendants _____ (indicate number)

6. Level of Involvement

Attending Physician/Dentist/Podiatrist Resident/Fellow

Consulting Physician/Dentist/Podiatrist PA, APRN, CNM Other _____

7. **Case History:** _____

8. **Malpractice Alleged:** _____

9. **Damages Alleged:** _____

10. **Name and Address of your Defense Attorney:** _____

11. **Printed Name of Person Completing this form:** _____