WEST VIRGINIA BOARD OF MEDICINE
101 Dee Drive, Suite 103
Charleston, West Virginia 25311
304.558.2921 Fax 304.558.2084

PROFESSIONAL LIABILITY CLAIM REPORT SUPPLIED BY THE PRACTITIONER

Practitioner's Name _____ License No. _____

Name of Insurance Company _____

Address of Insurance Company _____

_____

_____

Date of Loss _____

Claimant's Name _____

Date of Judgment _____ Amount $_____
or
Date of Settlement _____ Amount $_____

Additional Information _____

_____

_____

Practitioner's Signature _____

Today's Date _____