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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

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BOARD OF MEDICAL PRACTICE Physician Self Report Form

Your duty of self-reporting as required by 24 Del C., § 1731A is not complete until this form has been returned to the Board. This form may be duplicated.

Name of Physician License No. Office Telephone No.

Address City State Zip

Malpractice Complaint: (Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.)

Plaintiff's Name: _____ Age: _____ Sex: _____

Address of Record: _____

Date/Place of Occurrence: _____

Indicate your position in case, i.e., resident, primary physician, etc: _____

Filed Against: Individual Doctor Group Hospital

List names of other defendant-doctors and/or hospitals: _____

Disposition: Verdict Settled

Please provide the following information related to the verdict or settlement:

Civil Case No.: _____ Legal Attorney: _____

Final Disposition: _____

Date of Disposition: _____ Total Amount Paid (if any): _____

Insurance company covering you for this incident: _____

Amount attributable to you: _____

YOU MAY PROVIDE A DETAILED EXPLANATION OF THE MEDICAL ISSUES INVOLVED IN THE REFERENCED LITIGATION.

Signature: _____ Date: _____