



Medical Board of California

Report of Settlement, Judgment or Arbitration Award

Required by Section 801.01, California Business and Professions Code

Enforcement Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2528
Fax: (916) 263-2435
complaint@mbc.ca.gov

PLEASE CHECK THE APPROPRIATE BOX

- Section 801.01(b)(1) (Insurance Company) Section 801.01(b)(2) (Self-insured)
- Section 801.01(e) (Plaintiff's Counsel) Section 801.01(b)(3) (State or Local Government)
- Section 801.01(c) (Employer-Prof. Corp., Group Practice, Health Care Facility or Clinic)

REPORTING ENTITY

Name of Entity		Name of Person Preparing Report			
Street Address	City	State	Zip Code	Telephone Number	

PHYSICIAN/PROVIDER - SEE PAGE 2 FOR ADDITIONAL REQUIRED INFORMATION

Name		License Number	Specialty/Subspecialty		
Street Address	City	State	Zip Code		
Defense Counsel Name			Defense Counsel Telephone		
Defense Counsel Address - Street Address	City	State	Zip Code		

PLAINTIFF/CLAIMANT

Name		Relationship to Patient			
Street Address	City	State	Zip Code		
Patient Name	Patient Date of Birth	Deceased <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical Record Number	Date of Occurrence	
Hospital Name					
Hospital Address - Street Address	City	State	Zip Code		
Plaintiff's Counsel Name			Plaintiff's Counsel Telephone		
Plaintiff's Counsel Address - Street Address	City	State	Zip Code		

CASE INFORMATION - SEE PAGE 2 FOR ADDITIONAL REQUIRED INFORMATION

Case Resulted in: (Check one)		
<input type="checkbox"/> Settlement	<input type="checkbox"/> Judgment	<input type="checkbox"/> Arbitration Award
Enclose Copy of Supporting Documents (i.e., settlement agreement, judgment, etc.)		
Date Resolved	Total Amount of Award \$	Total Paid on Behalf of Physician \$
Name and Location of Court/Arbitrator	Filing Date	Docket Number

Failure to substantially comply with this section is a public offense punishable by a fine of not less than five hundred dollars (\$500) and not more than five thousand dollars (\$5000).

I certify under penalty of perjury under the laws of the State of California that to the best of my knowledge the information provided within this report and any attachments is true and correct.

Signature of Preparer

Date

PHYSICIAN/PROVIDER - ADDITIONAL REQUIRED INFORMATION

Enter the full name, address, license number and specialty of every licensee alleged to have acted improperly, whether or not that individual was a named defendant in the action and whether or not that individual was required to pay any damages pursuant to the settlement, arbitration award, or judgment.

Provider's Name and Address	License #	Specialty/Subspecialty	Amount Paid on Behalf of Physician (If Applicable)
			\$ _____ <input type="checkbox"/> Settlement <input type="checkbox"/> Judgment <input type="checkbox"/> Arbitration Award
			\$ _____ <input type="checkbox"/> Settlement <input type="checkbox"/> Judgment <input type="checkbox"/> Arbitration Award
			\$ _____ <input type="checkbox"/> Settlement <input type="checkbox"/> Judgment <input type="checkbox"/> Arbitration Award
			\$ _____ <input type="checkbox"/> Settlement <input type="checkbox"/> Judgment <input type="checkbox"/> Arbitration Award
			\$ _____ <input type="checkbox"/> Settlement <input type="checkbox"/> Judgment <input type="checkbox"/> Arbitration Award

CASE INFORMATION - ADDITIONAL REQUIRED INFORMATION

Enter a comprehensive summary of the facts, including the date of occurrence and whether a death occurred, and the role of the provider(s) in the care or professional services provided to the patient with respect to those services at issue in the claim or action. (Attach additional pages if necessary)

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******PLEASE NOTE******

California Business & Professions Code Section 801.01 (g) (3) requires every reporting entity that submits this report to include with the report copies of the records and depositions.

Records included Yes No (If not, please provide reason)
