



MANDATORY REPORT OF INSURERS REPORTING LICENSED HEALTH PROFESSIONALS

Insurers Reporting Licensed Health Professionals for adverse judgment or settlement as a result of a suit, claim or violation of insurance coverage, to Division of Public Health Investigations Unit.

STATE OF NEBRASKA Name and address change eff 7/1/07 per LB296
 DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH
 Office of PROFESSIONAL & OCCUPATIONAL INVESTIGATIONS
 1033 O Street, Suite 500 Lincoln, Nebraska 68508
 402-471-0175

PROFESSIONAL I AM REPORTING

Name:	First:	Middle/MI:	Last:	Maiden:	Date of Birth:
Work Address:	Street:				
	City:		State:	Zip:	
Home Address	Street:				
	City:		State:	Zip:	
Telephone	Home:		Work:		

LIST THE FIELD AND NUMBER FOR EACH NEBRASKA LICENSE, CERTIFICATE OR REGISTRATION HELD

License Field	License Number

Reporting Party

Name:	
Title:	
Organization:	
Address:	
Telephone No.	FAX No.
E-mail Address:	
Relationship to Health Care Professional:	

- 1. We have made a payment resulting from a professional liability claim.
- 2. We have taken an adverse action that affects the coverage provided by the insurer due to alleged:
 - Incompetence
 - Negligence
 - Unethical
 - Unprofessional conduct
 - Physical, mental or chemical impairment

Type of action taken

- Denial of coverage
- Refusal to renew coverage
- Coverage terminated or cancelled
- Coverage limited, reduced or modified
- Premium or rate increase
- Other

Date adverse action was taken: _____

- Person is subject to National Practitioner Data Bank requirements and Data Bank Supplement form completed.
- Person not subject to National Practitioner Data Bank and next page completed.

3. The insurer has reasonable grounds to believe that the practitioner has committed a violation of the regulatory provisions governing the profession or practitioner.

4. The Department has requested the insurer to provide information.

Patient or Client

Name:	Date of Birth:
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Address: _____

Location of act, omission or conduct being reported

Name: _____

Address: _____

Date of Occurrence: _____

Describe in detail the acts, omissions or conduct being reported

MALPRACTICE PAYMENT

Name of patient or client:

Address:

Name of court:

Address:

Date of judgement, settlement or award:

Date of payment:

Amount of payment:

Description of the facts surrounding the reason for the payment for the act or omission:

Date of occurrence: _____

Where did it occur?

How did the act or omission occur?

The nature of any injury, illness, damage or other loss upon which the claim was based:

Persons present at time of act or omission or with first hand knowledge:

Name	Title
Address	Telephone
Name	Title
Address	Telephone
Name	Title
Address	Telephone