OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

Enforcement Unit

REPORT OF SETTLEMENT, JUDGMENT OR ARBITRATION AWARD

(Required by Section 801.01 of the California Business and Professions Code)

*****PLEASE PRINT OR TYPE*****

PLEASE CHECK THE APPROPRIATE BOX

☐ Insurance Company - §801.01(b)(1) ☐ Self-Insured - §801.01(b)(2) ☐ Plaintiff's Counsel - §801.01(e)
☐ State or Local Government -§801.01(b)(3) ☐ Employer-Prof. Corp., group practice, health care facility or clinic - §801.01(c)

REPORTING ENTITY

1. Name of Entity:
2. Address:
3. Name of Person Preparing Report:
4. Telephone:

PHYSICIAN/PROVIDER

5. Name:
6. Address:
7. License Number:
8. Specialty/ Subspecialty:
9. Defense Counsel Name:
10. Defense Counsel Address:
11. Defense Counsel Telephone:
12. **SEE REVERSE SIDE FOR INSTRUCTIONS**

PLAINTIFF/CLAIMANT

13. Name:
14. Address:
15. Relationship to Patient:
16. Patient Name:
17. Patient Date of Birth:
18. Deceased: ☐ **Yes** ☐ **No**
19. Medical Record Number:
20. Date of Occurrence:
21. Hospital Name:
22. Hospital Address:
23. Plaintiff's Counsel Name:
24. Plaintiff's Counsel Address:
25. Plaintiff's Counsel Telephone:

26. **SEE REVERSE FOR INSTRUCTIONS**	**27.** Case Resulted in: (Check one) ☐ Settlement ☐ Judgment* ☐ Arbitration Award* ***Enclose Copy of Court Documents**	**28.** Date Resolved:	**29.** Total Amount of Award: **$**	**30.** Total Paid on Behalf of Physician: **$**

31. Name and Location of Court/Arbitrator:	**32.** Filing Date:	**33.** 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 ($5,000).

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**

REVERSE PAGE – REPORT OF SETTLEMENT, JUDGMENT OR ARBITRATION AWARD

12. 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	**License #**	**Specialty**	**Amount Paid on Behalf of Physician (*if applicable*)**
			$ ☐ **Settlement** ☐ **Judgment** ☐ **Arbitration Award**
			$ ☐ **Settlement** ☐ **Judgment** ☐ **Arbitration Award**
			$ ☐ **Settlement** ☐ **Judgment** ☐ **Arbitration Award**
			$ ☐ **Settlement** ☐ **Judgment** ☐ **Arbitration Award**
			$ ☐ **Settlement** ☐ **Judgment** ☐ **Arbitration Award**
			$ ☐ **Settlement** ☐ **Judgment** ☐ **Arbitration Award**

26. 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 of professional services provided to the patient with respect to those services at issue in the claim or action (Attach additional pages if necessary):

******PLEASE NOTE****: California Business & Professions Code Section 801.01 (h)(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):