Board of Behavioral Sciences
1625 North Market Blvd., Suite S200, Sacramento, CA 95834
Telephone (916) 574-7830 TTY: (800) 326-2297
www.bbs.ca.gov

REPORT OF SETTLEMENT, JUDGMENT OR ARBITRATION AWARD

Required by Section 801, 801.1, 802, California Business and Professions Code

PLEASE CHECK THE APPROPRIATE BOX:

Section 801 (Insurance Company) Section 801.1 (State or Local Government) Section 802 (Self-insured)

INSURER/PUBLIC ENTITY:

1. Name ______ 2. Telephone ______
3. Address ______

PROVIDER:

4. Name ______ 5. License Number ______
6. Address (es) ______ License Type ______
8. Counsel's Name: ______ 7. Policy Number ______
10. Address ______ 9. Counsel's Phone Number ______

11. NOTE: On reverse, enter full name(s) of other physicians or health care providers who were claimed or alleged to have acted improperly, whether or not such persons were as defendants, or whether or not any recovery or judgment was against such persons. If any monies were paid on behalf of those listed, please indicate the amount.

PLAINTIFF/CLAIMANT:

12. Name ______ DATE: ______
13. Address (es)
Business ______
Residence ______
14. Hospital Name and Address ______
15. Incident Date ______ 16. Date of Admittance ______
17. Patient Name ______ 18. Hospital Chart Number ______
19. Patient Date of Birth ______ 20. Deceased ☐ Yes ☐ No
21. Counsel's Name ______ 22. Counsel's Phone Number ______
23. Address ______

24. Enter on reverse, a description of summary of the facts which each claim, charge or judgment rested including date of occurrence. Explain specifically whether death or personal injury occurred as a result of the negligence, error or omission in practice, or rendering of unauthorized professional services by the insured. Attach additional sheets as necessary. Photocopies of any pertinent documents, which contain this information, may be attached instead.

25. Case Resulted in: (Check one)	26. Date Resolved:	27. Total Amount of Award:	28. Total Paid on Behalf of
☐ Settlement ☐ Judgment ☐ Arbitration Award		$	Physician:

29. Name and Location of Court/Arbitrator:	30. Filing Date:	31. Docket Number:

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 Responsible Agent or Insurer ______ Name and Title (Printed or Typed) ______ Date

11. (Continued):

Name: ____________________

License Number: ____________________

Address (if available): ____________________

24. (Continued):

Summary of facts: