

# California Participating Physician Application

## Addendum B

### Professional Liability Action Explanation

This Addendum is submitted to Good Samaritan Hospital herein, this Healthcare Organization <sup>1</sup>.

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

#### I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Street Address:	City:	
	State:	ZIP:

#### II. CASE INFORMATION

City, County and State where lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of patient:	Age of patient:
Location of Incident: <input type="checkbox"/> Hospital <input type="checkbox"/> My office <input type="checkbox"/> Other doctor's office <input type="checkbox"/> Surgery Center <input type="checkbox"/> Other, (please specify)			
Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc.):			
Allegation:			
Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, please provide company name, contact person, phone number, location and carrier's claim identification number of insurance company, or other liability protection company or organization.			
If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:  Name _____ Phone Number (    )  Name _____ Phone Number (    )			

<sup>1</sup> As used in the Information Release section of this Addendum, the term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.

Physician Name \_\_\_\_\_

