

FORM E MALPRACTICE QUESTIONNAIRE

INSTRUCTIONS: Complete, sign, and date this Questionnaire. Complete a separate form for each case in which you have ever been named as a defendant, even if you have been dismissed or even if the case is still pending. You must attach the appropriate documentation from the courts and mail it to the Board. Do not take shortcuts on documenting malpractice. You must give a detailed summary of your actual involvement in the treatment of the patient. Failure to do so can result in delays in the processing of your application. Summaries by your attorney or your insurance company are not accepted in lieu of this documentation. The Georgia Composite Medical Board requires a copy of the Plaintiff's Complaint, and either the Settlement Agreement, Dismissal Order or Summary Judgment. Copies can be your own, or obtained either from your attorney or county clerk's office, and must be 8-1/2" by 11" in size. Do not submit two-sided copies.

Full Name of Physician Business Telephone Number

Address City State Zip Code

None. If none, please complete information above. Then, sign and date the form and mail it to the Board.

Name of Patient: _____
Last Name First Name Middle Name

Age of Patient _____ Years

Date of Occurrence: _____

Location of Incident: _____
 Site _____

Address _____

City County State Zip

Position in Case: Intern Resident Primary Physician Other:

Filed Against: Individual Physician Group Hospital

List Names of Other Physicians/Hospitals: _____

Attach to this document a detailed, typewritten summary of the circumstances surrounding the incident and your involvement in your own words. Do not reference other documents – include them with the summary. Even if the incident occurred while you were an intern or resident, a summary must accompany this form.

Disposition: Pending Settled Dismissed

If settled, provide the following information: In Court Out of Court Date of settlement: _____

Total Amount of Settlement: \$ _____ Amount Attributable to you: \$ _____

******* IMPORTANT: THIS FORM IS INVALID WITHOUT YOUR SIGNATURE AND SIGNATURE DATE. *******

SIGNATURE (REQUIRED) DATE SIGNED