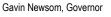


Board of Behavioral Sciences

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	<u> </u>
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 per If any monies were paid on behalf of those listed, please indicate the amount.	sons.
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 occurrenc Explain specifically whether death or personal injury occurred as a result of the negligence, error or omission in practice, or render unauthorized professional services by the insured. Attach additional sheets as necessary. Photocopies of any pertinent docume which contain this information, may be attached instead.	ring of
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

11. (Continued):

Name: License Number: Address (if available):

24. (Continued):

Summary of facts: