IMPORTANT NOTICE: This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under 225 of the Illinois Compiled Statutes 60/23. Disclosure of this information is REQUIRED. Failure to provide any required information shall result in a Class A Misdemeanor.	RETURN TO: ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION ENFORCEMENT ADMINISTRATION UNIT Mandatory Report File Custodian 320 West Washington Street Springfield, Illinois 62786 Mark envelope "Personal and Confidential"

MEDICAL MALPRACTICE PAYMENT

MEDICAL MANDATORY REPORT

MEDICAL DISCIPLINARY BOARD

GENERAL INSTRUCTIONS

Every insurance company which offers policies of professional liability insurance to persons licensed under the Illinois Medical Practice Act or any other entity which seeks to indemnify the professional liability of an individual licensed under the Act must report to the Medical Disciplinary Board the settlement of any claim or cause of action, or final judgement rendered in any cause of action, which alleges negligence in the furnishing of medical care by such licensed individual when such settlement or final judgment is in favor of plaintiff.

Reports must be filed with the Medical Disciplinary Board in writing within 60 days after a determination that a report is required.

This report contains two parts.

Part 1 seeks basic information concerning the person making the report, the licensed individual who is the subject of the report, and any patient who may have been injured or endangered as a result of the licensed individual's conduct or disability.

Part 2 seeks specific information concerning the conduct or disability of the licensed individual and any administrative or judicial action which may have resulted.

Both parts must be filled out completely. Where requested, **identify and attach explanatory documentation** which will be helpful to the Medical Disciplinary Board in determining whether further investigation is warranted, except that no medical records may be revealed without the written consent of the patient.

The law requires that this report be kept strictly confidential. All communications regarding this report should be addressed only to authorized persons.

The law further provides that any individual or organization acting in good faith, and not in a willful and wanton manner, in complying with this law by providing any report or other information to the Board, or assisting in the investigation or preparation of such information, or by participating in proceedings of the Board, shall not, as a result of such actions, be subject to criminal prosecution or civil damages.

MEDICAL MALPRACTICE PAYMENT

MEDICAL MANDATORY REPORT

PART 1 – BASIC INFORMATION

Official Use Only	
Code	Mandatory Report Number
3	**MR --**

A. SOURCE OF INFORMATION – (Individual making report)

NAME (Last, First, MI): _____

PROFESSIONAL TITLE AND/OR JOB TITLE: _____

NAME OF INSURANCE CO. OR INDEMNIFYING ENTITY: _____

ADDRESS: _____
Street Address City State ZIP Code

TELEPHONE NO.: _____ EMAIL ADDRESS: _____
Include Area Code

B. SUBJECT OF REPORT – (Individual licensed under the Medical Practice Act. Please complete a separate report for each individual.)

NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

TELEPHONE NO.: _____ EMAIL ADDRESS: _____
Include Area Code

PROFESSIONAL LICENSE NO.: _____

C. CLAIMANT INFORMATION – (If more than one patient is involved, please check the appropriate box and provide information regarding additional patients on Page 4, "Multiple Patients Report," of this form)

CLAIMANT/PLAINTIFF NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

TELEPHONE NO.: _____ EMAIL ADDRESS: _____
Include Area Code

DOB: _____ DATE OF OCCURRENCE GIVING RISE TO CLAIM: _____

If patient is other than the claimant or plaintiff, complete the following, otherwise, enter "same as above."

MULTIPLE PATIENTS? ☐

PATIENT NAME: _____ DOB: _____

D. PLAINTIFF'S ATTORNEY INFORMATION

ATTORNEY NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

TELEPHONE NO.: _____ EMAIL ADDRESS: _____
Include Area Code

PART 2 – SPECIFIC INFORMATION

A. NEGLIGENCE ALLEGED BY CLAIMANT OR PLAINTIFF – In the space below, please provide a brief description of any acts or omissions alleged to have caused injury and the extent of any injury including the dates of any occurrences (**identify and attach any appropriate documents** including pleadings and expert witness opinions, if applicable):

Did the injury result in the death of the claimant? ☐ Yes ☐ No

B. SETTLEMENT OR FINAL JUDGMENT INFORMATION

Amount of settlement or final judgment paid on behalf of the subject of the report: _____

Amount paid on behalf of any other persons against whom a claim was made or lawsuit filed for the occurrence being reported: _____

Date of settlement or final judgment: _____

C. COURT ACTION – (Attach copies of any appropriate pleadings you may have including appearances and orders.)

Did the act(s) result in any court action, civil or criminal?
☐ **Yes** ☐ **No** If yes, please identify.

Case Name: _____

_____

Court in which filed: _____

_____

Docket Number: _____

Date Filed: _____

Status of Court Action: _____

_____

D. CLAIM HISTORY OF SUBJECT OF REPORT

Number of previous claims or lawsuits filed against the subject: _____

With respect to each such claim, briefly describe its nature including the dates of any occurrences giving rise to the claim, and its disposition including the date and amount of any settlement or judgment:

PART 3 - SIGNATURE			OFFICAL USE ONLY
NAME	TITLE	DATE	

MULTIPLE PATIENTS REPORT

Official Use Only

MR -

ATTACH DESCRIPTION OF FACTS THAT PERTAIN TO EACH CASE AND, IF APPLICABLE, ATTACH ADDITIONAL DOCUMENTATION

A.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____

B.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____

C.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____

D.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____

E.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____

F.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____

G.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____

H.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____