



## Arkansas State Medical Board

1401 West Capitol, Suite 340  
Little Rock, AR 72201  
(501)296-1802 FAX (501)603-3555

### PLEASE TYPE OR PRINT LEGIBLY

Arkansas law requires that all physicians having had a malpractice claim filed against them, complete this form and return it to the above address (one complaint per form).

#### REGULATION 23 MALPRACTICE REPORTING

Pursuant to Ark. Code Ann. § 17-95-103, requires every physician licensed to practice medicine and surgery in the State of Arkansas to report to the Arkansas State Medical Board within ten (10) days after receipt of notification of any claim or filing of a lawsuit against him charging him with medical malpractice. The notice from the physician to the Board shall be sent by registered letter upon such forms as may be obtained at the office of the Board. In addition to completing the form, the physician should attach a copy of the complaint to this form if a lawsuit has been filed against him.

Should a physician fail to comply with the terms of Ark. Code Ann. § 17-95-103 and this Regulation, then the same, shall be cause for revocation, suspension, or probation or monetary fine as may be determined by the Board; after the bringing of formal charges and notifying the physician as required by the Medical Practices Act and the Administrative Procedure Act. History: Adopted August 12, 1999

PLEASE NOTE: Registered mail does not provide proof of delivery to our office. Please use a delivery method requiring a signature, for confirmation of receipt.

1. Physician's Name: \_\_\_\_\_ License # \_\_\_\_\_  
Address: \_\_\_\_\_
2. Name of Claimant: \_\_\_\_\_
3. Claimant's Attorney: \_\_\_\_\_
4. Have allegations been reduced to lawsuit? \_\_\_\_\_
5. Check most appropriate allegation(s) of malpractice listed against you from this complaint.  
Negligence \_\_\_\_\_ Standard of Care \_\_\_\_\_ Wrongful Death \_\_\_\_\_ Failure to Diagnose \_\_\_\_\_ Acts of Omission \_\_\_\_\_  
Failure to Render Correct/Proper Treatment \_\_\_\_\_ Carelessness \_\_\_\_\_ Failure to Refer \_\_\_\_\_ Other \_\_\_\_\_
6. Date claim was filed: \_\_\_\_\_ Date of Incident: \_\_\_\_\_
7. Facility where incident occurred: \_\_\_\_\_  
(Name, City, State)
8. Brief statement of diagnosis and procedures, which relates to the act(s) of malpractice alleged to have been committed by you. **"SEE COMPLAINT or SEE ATTACHED" IS NOT ACCEPTABLE.**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. What malpractice company covered this incident? \_\_\_\_\_  
Policy # \_\_\_\_\_ Amount of coverage \$ \_\_\_\_\_
10. Has settlement been made? \_\_\_\_\_  
Date of settlement \_\_\_\_\_
11. Amount of settlement: \$ \_\_\_\_\_