



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

PHYSICIAN SELF-REPORT FORM

The Physician's mandatory duty to self-report is in 24 Del C. § 1730 and § 1731A. To comply with your duty, complete and submit this form to the Board of Medical Licensure and Discipline within the required time limit. You may duplicate the form.

IDENTIFYING AND CONTACT INFORMATION

- Physician Name: _____
Last First Middle
- Delaware License No: C ___ - _____
- Mailing Address: _____
City State Zip
- Office Phone: _____ Email: _____

MALPRACTICE COMPLAINT

- Plaintiff Name: _____ Age: _____ Sex: _____
- Address of Record: _____
- Date of Occurrence: _____
- Place of Occurrence (office, hospital name & address): _____
- What was your position in case (e.g., resident, primary physician)? _____
- Who was the complaint filed against? Individual Doctor Group Hospital
- Names of other defendant-doctors and/or hospitals: _____

DISPOSITION

- What was the disposition? Verdict Settled
- Final Disposition: _____ Date: _____
- Civil Case No.: _____ Attorney: _____
- Total Amount Paid (if any): _____
- Amount Attributable to You: _____
- Insurance Company Covering You for this Incident: _____

Signature: _____ **Date:** _____

You may attach a detailed explanation of the medical issues involved in the referenced litigation.