



**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 \_\_\_\_\_  
 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 persons. If any monies were paid on behalf of those listed, please indicate the amount.

### 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 occurrence. Explain specifically whether death or personal injury occurred as a result of the negligence, error or omission in practice, or rendering of unauthorized professional services by the insured. Attach additional sheets as necessary. Photocopies of any pertinent documents, which contain this information, may be attached instead.

25. Case Resulted in: (Check one)  
☐ Settlement ☐ Judgment ☐ Arbitration Award

26. Date Resolved: \_\_\_\_\_

27. Total Amount of Award: \_\_\_\_\_

\$ \_\_\_\_\_

28. Total Paid on Behalf of  
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

\_\_\_\_\_  
Name and Title (Printed or Typed)

\_\_\_\_\_  
Date

11. (Continued):

Name:

License Number:

Address (if available):

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24. (Continued):

Summary of facts: