

**Board of Registration in Medicine**

200 Harvard Mill Square, Suite 330  
Wakefield, MA 01880 Telephone: (781) 876-8210 Fax: (781) 876-8383  
Website: www.massmedboard.org

**MALPRACTICE HISTORY**

**Applicant's Instructions:** Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

**Waiver for Release of Information**

I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

**Liability Carrier's Instructions:** If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: \_\_\_\_\_ **From:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **To:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Liability Carrier: \_\_\_\_\_ **From:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **To:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Liability Carrier: \_\_\_\_\_ **From:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **To:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Applicant's signature: \_\_\_\_\_ /\_\_\_\_/\_\_\_\_  
Date

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_