SENTINEL

CLAIM REPORTING: MEDICAL PROFESSIONAL LIABILITY

Named Insured: _____

Best Contact to Answer Questions on the Claim: _____

Phone: _____ Email: _____

Date of Incident: _____ Location of Incident: _____

Practitioner Involved: _____

Patient Information:

Description of Incident:

Type of Injury: _____

Fatality: ☐ Yes ☐ No

Additional Treatment Needed as a Result:

Please Share Any Other Pertinent Details: