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: