State of Idaho
Division Of Occupational and Professional Licenses
Prelitigation

BRAD LITTLE
Governor
RUSSELL BARRON
Administrator

11341 W Chinden Blvd.
P.O. Box 83720
Boise, ID 83720-0063
(208) 334-3233
dopl.idaho.gov

MEDICAL MALPRACTICE PRELITIGATION CLAIM FORM

Please use this form to request a hearing for prelitigation consideration of a personal injury claim for money damages.

PLEASE NOTE: THIS IS **NOT** A COMPLAINT FORM

Please email, fax, or mail a printed or typed claim form to:

State of Idaho Division of Occupational and Professional Licenses – Prelitigation
PO Box 83720, Boise, Idaho, 83720-0063
Express Mail: 11341 W Chinden Blvd. Bldg 4 Boise Idaho, 83714
Email: bom-prelitigation@dopl.idaho.gov Fax: 208-327-7005

COMPLAINANT: _____

Telephone: _____ Cell: _____ Fax: _____

Address: _____

City/State/Zip: _____

Email: _____

COUNSEL: _____

Telephone: _____ Cell: _____ Fax: _____

Address: _____

City/State/Zip: _____

Email: _____

To complete your application and claim, please set forth in writing and in general terms for **each Respondent**, *by whom, where, when* and *facts supporting your claim that malpractice occurred* and the healthcare in question that was allegedly and improperly provided or withheld that resulted in the untoward result or contributed to the injury as well as *damages claimed*. Please use additional sheets of paper if necessary.

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RESPONDENT #1: _____

FULL name of physician (MD or DO) or acute care general hospital

Telephone: _____ Cell: _____ Fax: _____

Address: _____

City/State/Zip: _____

Email: _____

WHEN: Date(s) (DD/MM/YY) for each alleged incident the healthcare in question was allegedly improperly provided or withheld by the physician and/or acute care general hospital.

_____

FACTS TO SUPPORT YOUR CLAIM THAT MALPRACTICE OCCURRED:

_____

_____

_____

_____

_____

MONEY DAMAGES CLAIMED:

_____

*If there are additional respondents, please list them and claim information on an additional sheet(s) of paper.

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RESPONDENT #2: _____

FULL name of physician (MD or DO) or acute care general hospital

Telephone: _____ Cell: _____ Fax: _____

Address: _____

City/State/Zip: _____

Email: _____

WHEN: Date(s) (DD/MM/YY) for each alleged incident the healthcare in question was allegedly improperly provided or withheld by the physician and/or acute care general hospital.

_____

FACTS TO SUPPORT YOUR CLAIM THAT MALPRACTICE OCCURRED:

_____

_____

_____

_____

_____

MONEY DAMAGES CLAIMED:

_____

*If there are additional respondents, please list them and claim information on an additional sheet(s) of paper.