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.
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.

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FACTS TO SUPPORT YOUR CLAIM THAT MALPRACTICE OCCURRED:

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MONEY DAMAGES CLAIMED:

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

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FACTS TO SUPPORT YOUR CLAIM THAT MALPRACTICE OCCURRED:

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MONEY DAMAGES CLAIMED:

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