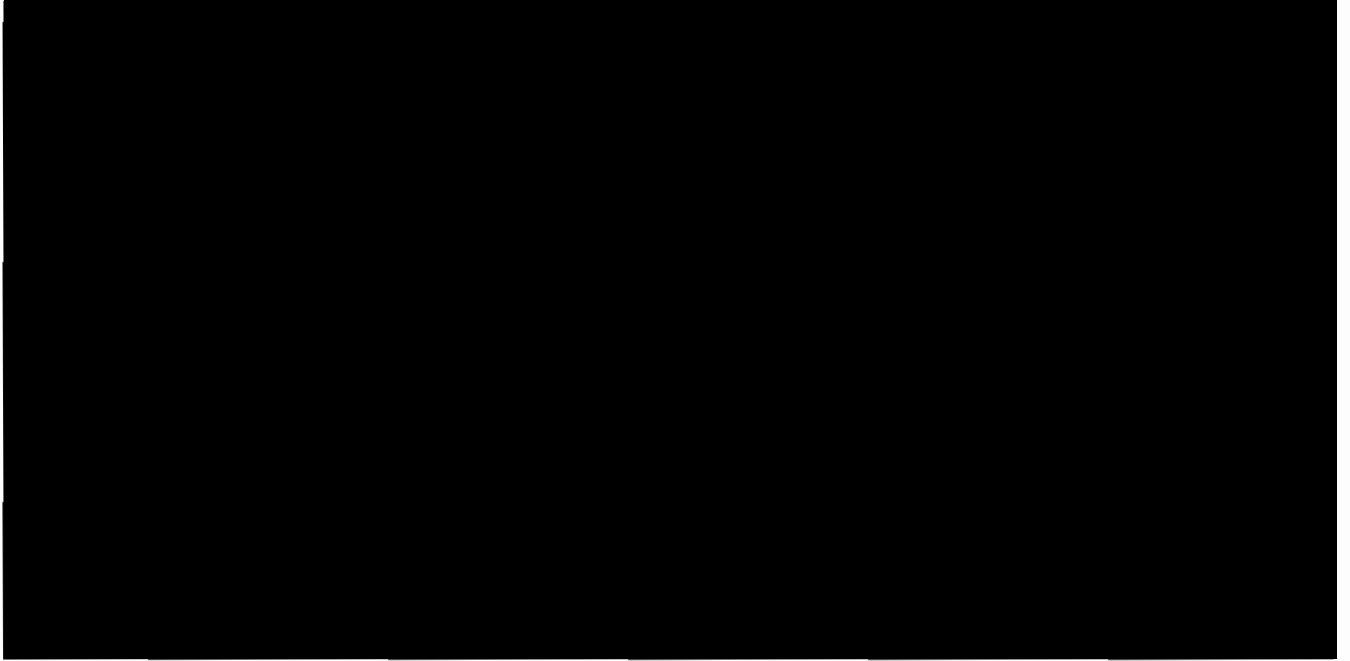


Philip Westerman



Your Legal Representative in this matter (include name, address and telephone number)

Name \_\_\_\_\_  
Firm \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone \_\_\_\_\_

**Indicate Decision, Appeal, Settlement, Dismissal:**

If a Court or Arbitration Panel heard your case, indicate the following:

Court \_\_\_\_\_

Court's location \_\_\_\_\_

Docket number \_\_\_\_\_

Date the action was filed \_\_\_\_\_

Decision determined by (check one): \_\_\_\_\_ Judge \_\_\_\_\_ Jury \_\_\_\_\_ Arbitration Panel

Decision: \_\_\_\_\_ Award: \_\_\_\_\_

If your case was appealed, indicate the following: Date appeal filed (month, day, year) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date appeal decided: (month, day, year) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If your case was settled, indicate the following: \_\_\_\_\_

Settlement amount paid on your behalf: \_\_\_\_\_

Total settlement amount: \_\_\_\_\_

**Important:** In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

27. Medical Malpractice Court Judgments/Settlements [See 26 VSA § 1368(a)(6A)]

A. Judgments

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases; complete the below information and provide copies of papers fully documenting these matters.

Judgment  Arbitration

\_\_\_\_\_  
(Date) (Court) (State) (Nature of Case) (Amount Assessed Against You)

If necessary, please use an additional sheet and check this box: .....

B. Settlements

Please provide a description of all pending settlements and settlements of medical malpractice claims against you. Please complete the below information and provide copies of papers fully documenting these matters.

\_\_\_\_\_  
(Date) (Court) (State) (Amount Assessed Against You)

If necessary, please use an additional sheet and check this box: .....

Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer \_\_\_\_\_

Claimant Name \_\_\_\_\_

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:

1. Patient's condition at point of your involvement;
2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

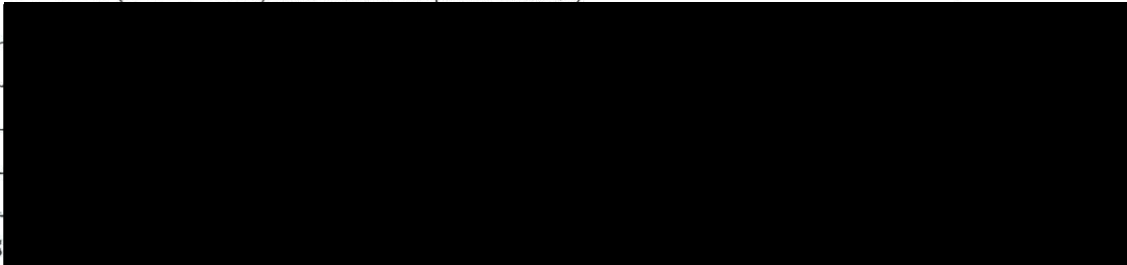
Your role (circle one):

- |                               |                                     |
|-------------------------------|-------------------------------------|
| 01 Anesthesiologist           | 11 PGY 4                            |
| 02 Primary Care Physician     | 12 PGY 5                            |
| 03 Referring Physician        | 13 PGY 6                            |
| 04 <u>Attending Physician</u> | 14 PGY 7                            |
| 05 Consultant Specialist      | 15 Workman's Compensation Evaluator |
| 06 <u>Surgeon</u>             | 16 Court Psychiatrist               |
| 07 Fellow                     | 17 On-Call Physician                |
| 08 PGY 1                      | 18 Group Practitioner/Partner       |
| 09 PGY 2                      | 19 Other: Specify _____             |
| 10 PGY 3                      | 20 Unknown                          |



Your Legal Representative in this matter (include name, address and telephone number)

Name \_\_\_\_\_  
Firm \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone \_\_\_\_\_



Indicate Decision, Appeal, Settlement

If a Court or Arbitration Panel heard your case, indicate the following:

Court \_\_\_\_\_

Court's location \_\_\_\_\_

Docket number \_\_\_\_\_

Date the action was filed \_\_\_\_\_

Decision determined by (check one): \_\_\_\_\_ Judge \_\_\_\_\_ Jury \_\_\_\_\_ Arbitration Panel

Decision: \_\_\_\_\_ Award: \_\_\_\_\_

If your case was appealed, indicate the following: Date appeal filed (month, day, year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date appeal decided: (month, day, year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

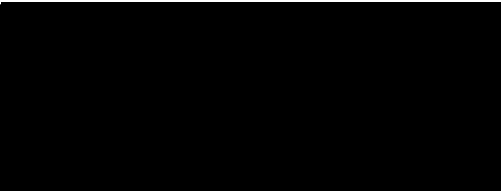
If your case was settled, indicate the following:

Settlement amount paid on your behalf \_\_\_\_\_

Total settlement amount: \_\_\_\_\_

Date of settlement: (month, day, year) \_\_\_\_\_

Case dismissed against you \_\_\_\_\_ Against all defendants \_\_\_\_\_



Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

sw

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\_\_\_\_\_

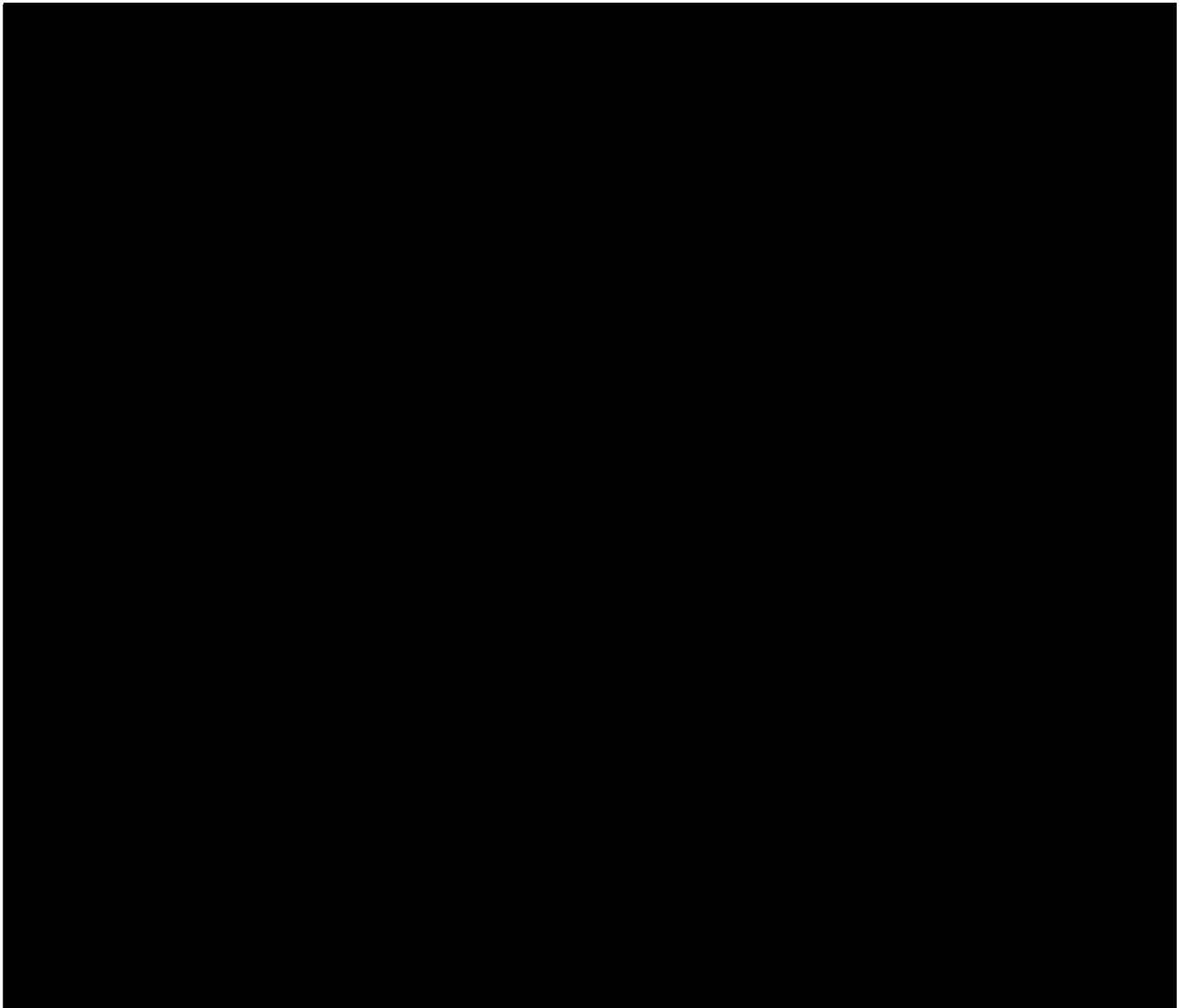
\_\_\_\_\_

\_\_\_\_\_

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

Your role (circle one):

- |                                 |                                     |
|---------------------------------|-------------------------------------|
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Your Legal Representative in this matter (include name, address and telephone number)

Name \_\_\_\_\_

Firm \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_

Indicate Decision, Appeal, Settlement \_\_\_\_\_

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Court \_\_\_\_\_

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Docket number \_\_\_\_\_

Date the action was filed \_\_\_\_\_

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Decision: \_\_\_\_\_ Award: \_\_\_\_\_

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Date appeal decided: (month, day, year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

If your case was settled, indicate the following:

Settlement amount paid on your behalf: \_\_\_\_\_

Total settlement amount: \_\_\_\_\_

Date of settlement: (month, day, year) \_\_\_\_\_

\_\_\_\_\_ Case dismissed against you \_\_\_\_\_ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

\_\_\_\_\_

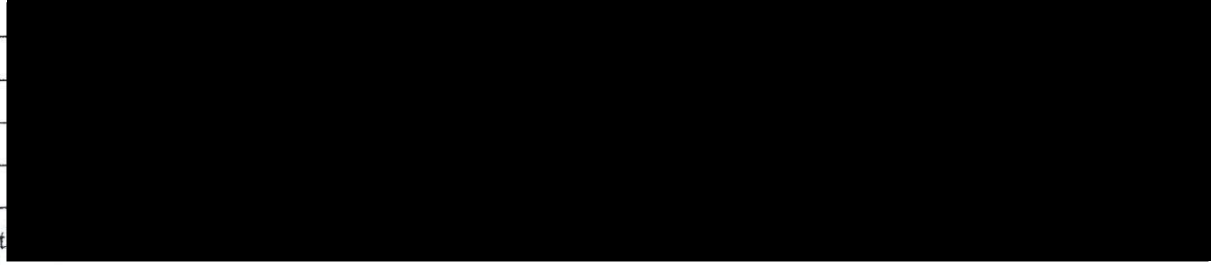
Your role (circle one):

- |                           |                                     |
|---------------------------|-------------------------------------|
| 01 Anesthesiologist       | 11 PGY 4                            |
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Court \_\_\_\_\_

Court's location \_\_\_\_\_

Docket number \_\_\_\_\_

Date the action was filed \_\_\_\_\_

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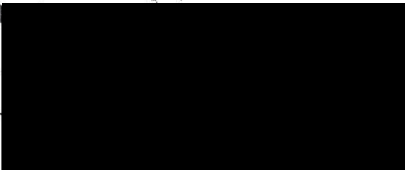
Date appeal decided: (month, day, year) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If your case was settled, indicate the fol

Settlement amount paid on your behalf:

Total settlement amount: \_\_\_\_\_

Date of settlement: (month, day, year)



\_\_\_\_\_ Case dismissed against you \_\_\_\_\_ Against all defendants

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\_\_\_\_\_  
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\_\_\_\_\_

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- |                           |                                     |
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| 01 Anesthesiologist       | 11 PGY 4                            |
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