New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100

Malpractice Insurance Verification

_____ has applied for a podiatry license with the State
Insured's Name
of New Jersey. He/she held medical malpractice insurance issued by your company. Please complete this form, attach relevant supporting documentation concerning any medical malpractice cases in which this practitioner was named and the business card of the individual completing this form and return directly to: BMEApp@dca.njoag.gov

_____
Malpractice Insurance Company Name

_____
Street Address City State ZIP code (Area Code) Phone

Dates of coverage: from: _____ /_____ /_____to: _____ /_____ /_____

Dates should include entire period the insured was covered, not just the dates of the current policy.

List the name(s) and status of each case in which the podiatrist has been involved. Attach supporting documents concerning the status of the case.

Plaintiff's Name	**Status**
_____	_____
_____	_____
_____	_____
_____	_____

1. Was this podiatrist ever denied malpractice coverage? ☐ Yes ☐ No
2. Was this podiatrist's practice ever curtailed or limited? ☐ Yes ☐ No
3. Was this podiatrist ever assessed a surcharge based upon specific claims history? ☐ Yes ☐ No
4. Was office monitoring or special hospital monitoring ever required for this podiatrist? ☐ Yes ☐ No
5. Was this doctor ever subjected to underwriting review based upon specific claims history or for any other cause? ☐ Yes ☐ No

_____
Print the name and title of the person completing this form.

_____
Signature

_____
Date form completed