STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
BOARD OF REGISTERED NURSING
PO BOX 944210, Sacramento, CA 94244-2100
P (916) 322-3350 | TTY (800) 326-2297 | www.rn.ca.gov

REPORT OF SETTLEMENT, JUDGMENT OR ARBITRATION AWARD

by Professional Liability Insurance Carriers
Pursuant to Section 800, 801, 804 of the California Business and Professions Code

INSUROR		
Name:	Telephone:	
Address:		
City:	State:	Zip:

RN/PROVIDER		
Name:	License #:	
Address:		
City:	State:	Zip:
Policy Number:		
Counsel's Name:		
Address:		
City:	State:	Zip:
NOTE: On reverse, enter full name(s) of other RNs or health care providers who were claimed or alleged to have acted improperly, whether or not such persons were named as defendants, or whether or not any recovery or judgment was against such persons. If any monies were paid on behalf of those listed, please indicate the amount.		

PLAINTIFF/CLAIMANT		
Name:		
Address:		
City:	State:	Zip:
Hospital Name:		
Hospital Address:		
Incident Date:	Date of Admittance:	
Hospital Chart #:	Patient Date of Birth:	
Counsel's Name:		
Address:		
City:	State:	Zip:
Enter, on reverse, a description or summary of the facts upon which each claim, charge or judgment rested including date of occurrence. Explain specifically whether death or personal injury occurred as a result of the negligence, error or omission in practice, or rendering of unauthorized professional service by the insured. (Attach additional sheets as necessary. Photocopies of any pertinent documents, which contain this information, may be attached instead.)		
Case Resulted in: (check one) ☐ **Settlement** ☐ **Judgment** ☐ **Arbitration**		
Date Resolved:	Amount of Settlement:	
Filing Date:	Total Paid on Behalf of RN:	
Name/Location of Court/Arbitrator:	Docket #:	

I certify under penalty of perjury under the laws of the State of California that to the best of my knowledge the information provided within this report and any attachments is true and correct.

Signature of Responsible Agent or Insurer **Name and Title** **Date**