Professional Liability
KANSAS CLOSED CLAIMS REPORT
As required by
K.S.A. 40-1126 through K.S.A. 40-1127

Name of Insurance Company: _____

Company Claim File Number: _____

---

(1) Health Care Provider's Name: _____

(2) Health Care Provider's License or Registration Number: _____

(3) Date of Occurrence Giving Rise to the Action: _____

(4) Plaintiff's Name: _____

(5) Name of injured Party if Different than #4: _____

Note: Entering "not available" in any of the above blanks will not be acceptable unless a specific explanation is attached indicating a justifiable reason for not providing the requested information.

----------fold----------

SEND TO THE ATTENTION OF: _____

KANSAS BOARD OF HEALING ARTS
800 SW Jackson
Lower Level – Suite A
Topeka, KS 66612

Name of Company Representative Completing Form: _____

_____

Telephone Number: _____