

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: \_\_\_\_\_

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(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.

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SEND TO THE ATTENTION OF: \_\_\_\_\_

KANSAS BOARD OF HEALING ARTS  
800 SW Jackson St., Suite 700  
Topeka, KS 66612

Name of Company Representative  
Completing Form: \_\_\_\_\_

\_\_\_\_\_  
Telephone Number: \_\_\_\_\_