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.

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: ___________________