Montana Chiropractic Legal Panel
PO Box 1098
Helena, Montana 59624-1098

Gail A. Tronstad
Director

(406) 442-4141
gail.tronstad@gmail.com

Application for Review of Claim

INFORMATION AS TO PARTIES:

CLAIMANT:

Name _____ Telephone_____

Address _____
Street or PO Box City State Zip

Status of Claimant – check one ☐ Patient ☐ Other

Patient's name if different from claimant _____

CLAIMANT'S LEGAL COUNSEL:

Name _____ Telephone_____

Address _____
Street or PO Box City State Zip

CHIROPRACTIC PHYSICIAN AGAINST WHOM CLAIM IS MADE:

Name _____ Telephone_____

Address _____
Street or PO Box City State Zip

If additional parties are involved, please attach a separate listing of their names, addresses and telephone number under this category designation.

OTHER NECESSARY AND PROPER PARTIES NOT DESIGNATED CHIROPRACTIC PHYSICIANS:

There are _____ other parties who are necessary or proper parties for any court action which might subsequently arise out of the same factual circumstances as set forth in this application. Please provide name of each.

Name _____ Telephone_____

Name _____ Telephone_____

INFORMATION AS TO CLAIM:

SEPARATE SPECIFIC ACCOUNT OF CLAIM:

On a separate sheet of paper, please set out in reasonable detail:

1. The elements of the chiropractic physician's conduct (either acts or omissions or both) that are believed to constitute a claim of malpractice

2. The places and dates the acts or omissions occurred.

3. The names and addresses of all chiropractic physicians, hospitals, medical doctors, and other health care providers and facilities having contact with the patient, relative to the incident or incidents in question. Specify whether such are parties to the claim or merely individuals or entities having had contact with the patient relative to the incident.

4. The name, address and phone of all other witnesses to the incident in question.

CLAIM INFORMATION:

For panel purposes, even if the following information is provided in your separate specific account of the claim, please indicate as to primary incident.

1. Date of occurrence of incident _____

2. Date of discovery of incident by patient _____

3. Place of incident: County: _____

   Location – Check one
   ☐ Chiropractic Physician's Office
   ☐ Hospital
   ☐ Other. Please specify _____

AUTHORIZATION TO RELEASE INFORMATION:

Please have the claimant sign and return two copies of a completed consent form for each chiropractic physician, health care provider, health care facility or hospital having had contact with the patient relative to the incident even if not name as a party to the claim.

The undersigned as ☐ CLAIMANT or ☐ CLAIMANT'S ATTORNEY, requests consideration of the above claim, including all attached materials by the Montana Chiropractic Legal Panel, in accordance with the statute 27-12-101 MCA and rules of the Panel.

Signed _____ **Date** _____

Printed or typed name _____

Submit to: Gail Tronstad, Director
Montana Chiropractic Legal Panel
PO Box 1098
Helena, MT 59624-1098