HSHS St. John's Hospital

Request for Liability Coverage and Malpractice History

Complete the document below and return to Medical Staff Services via email at Teresa.Daenzer@hshs.org or fax at 217-525-5673.

Please provide your information below.

Name: _____

Employer: ☐ HSHS St. John's Hospital ☐ Memorial Medical Center

Specialty: _____

Dates of Residency: _____

Email: _____

Phone Number: _____

I authorize and request HSHS St. John's Hospital to release information to those named below regarding professional liability insurance coverage and history of malpractice claims, including any actions for damages, pending or closed, whether or not there has been a final disposition.

Signature: _____ Date: _____

If you would like us to send your malpractice information to someone on your behalf, you must provide their information below. You only need to provide either the fax number or the email.

Name: _____

Fax Number: _____

Email: _____

It will take approximately 1 week to obtain the malpractice verification. It is recommended that you also request this information from Memorial Medical Center.