



North Dakota Workforce
Safety & Insurance

**THIRD PARTY NOTICE AND
QUESTIONNAIRE –
MEDICAL MALPRACTICE**
LEGAL DIVISION
SFN 58278 (07/2014)

1600 EAST CENTURY AVENUE, SUITE 1
PO BOX 5585
BISMARCK ND 58506-5585
Telephone 1-800-777-5033
Toll Free Fax 1-888-786-8695
TTY (hearing impaired) 1-800-366-6888
Fraud and Safety Hotline 1-800-243-3331
www.WorkforceSafety.com

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|----------------|-------------|
| Injured Worker | |
| Claim Number | Injury Date |

1. Do you believe that negligence of a medical professional is the cause of any worsening of your work injury? Yes No

If yes, please provide the name and address of the medical professionals likely responsible.

2. Name and address of the medical professionals' insurance company , if known.

3. Please describe what the medical professional did, or did not do, which caused any worsening of your work injury.

4. a. Have you been in contact with any insurance company of these medical professionals?
 Yes No

b. If yes, please disclose the dates of contact _____

c. The name of your contact person _____

d. Amount of monetary settlement or recovery you have received or agreed to \$ _____

5. Do you intend to pursue legal action against a medical professional?
 Yes No

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|----------------|--------------|
| Injured Worker | Claim Number |
|----------------|--------------|

Please note: Section 65-01-09 of the North Dakota Century Code allows for a portion of your attorney's fees and costs to be paid by WSI if there is a recovery in a third party action.

6. Please identify the name and address of your attorney, if you have retained one in connection with this matter.

7. If you have not received a monetary settlement from the third party or their insurance company, are settlement negotiations in progress? Yes No

8. Is settlement being considered? Yes No

By signing this document, I certify that the information provided herein is true and correct to the best of my knowledge. I understand that I must notify WSI at the time I begin to pursue settlement negotiations and/or seek the assistance of an attorney in this matter.

I also acknowledge I have carefully reviewed the following Lien Notice: WSI has a lien in the full amount it has paid in all benefits for this claim. This lien attaches to all claims, demands, settlement proceeds, judgment awards, or insurance payable by reason of a legal liability of a third person. If you receive any money in regard to this claim from a third person or their insurance company, and WSI does not receive payment of its lien within thirty days of their payment to you, WSI may sue you and/or your personal injury attorney for the full amount of the lien. No release of liability or satisfaction of any judgment, claim or demand is valid or effective against WSI's lien.

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| Injured Worker's Signature | Date |
|----------------------------|------|