

Name

Address

Phone

Email

Attorney for ☐ Inquiring Party(s) ☐ Health Care Provider(s)

OFFICE OF ADMINISTRATIVE HEARINGS
MEDICAL INQUIRY AND CONCILIATION PANELS
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
STATE OF HAWAII

In the Matter of the Inquiry of

Inquiring Party(s),

vs.

Health Care Provider(s).

MICP No. _____

Check one:

☐ INQUIRING PARTY(S)

☐ HEALTH CARE PROVIDER(S)

PROCEEDING STATEMENT;
CERTIFICATE OF SERVICE

PROCEEDING DATE: _____

TIME: _____

☐ INQUIRING PARTY(S) ☐ HEALTH CARE PROVIDER(S)
PROCEEDING STATEMENT

I. NOTICE OF THE INQUIRY (Brief summary of inquiry/response to inquiry)

II. INQUIRING PARTY(S)/HEALTH CARE PROVIDER(S) THEORY OF THE INQUIRY

Acts or omissions by the health care providers which inquiring party believes constitutes negligence by Health Care Providers (Health Care Provider's response to inquiry)

III. UNDISPUTED FACTS (List any significant facts which the parties agree upon)

1.

2.

3.

☐ Check box if additional page(s) attached

III. WITNESSES

A. Witnesses

1.

2.

B. Lay Witnesses

1.

2.

V. EXHIBITS (List and describe each exhibit)

1.

2.

3.

☐ Check box if additional page(s) attached

VI. LEGAL QUESTIONS (List any legal questions or issues that will be raised in the proceeding)

1.

2.

3.

☐ Check box if additional page(s) attached

DATED: Honolulu, Hawai'i,_____.

☐ INQUIRING PARTY ☐ HEALTH CARE PROVIDER
Attorney for Inquiring Party(s)/Health Care Provider(s)

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Check one:

☐ INQUIRING PARTY(S)

☐ HEALTH CARE PROVIDER(S)

vs.

CERTIFICATE OF SERVICE

Health Care Provider(s).

CERTIFICATE OF SERVICE

I hereby certify that on this date, I caused a true and correct copy of the foregoing document to be duly served on the following person at the address indicated, via first class mail, postage prepaid, hand delivery, or electronically (as indicated below):

Hand Delivered

Mail

Email

[Name & address of person served]

☐☐☐

DATED: Honolulu, Hawai'i, _____.

☐ INQUIRING PARTY ☐ HEALTH CARE PROVIDER
Attorney for Inquiring Party(s)/Health Care Provider(s)