



NEW HAVEN COUNTY BAR ASSOCIATION LAWYER REFERRAL SERVICE

CERTIFICATION AND AGREEMENT MEDICAL/DENTAL MALPRACTICE PANEL

I hereby certify that I have handled five (5) personal injury or medical/dental malpractice matters to resolution (i.e. settlement or verdict) during the past three years.

Court_____Case Name_____Case #_____Year_____

Court_____Case Name_____Case #_____Year_____

Court_____Case Name_____Case #_____Year_____

Court_____Case Name_____Case #_____Year_____

Court_____Case Name_____Case #_____Year_____

AND
(Either A or B)

(A.) I hereby certify that I have tried at least two (2) other personal injury cases to jury verdict.

Court_____Case Name_____Case #_____Year_____

Court_____Case Name_____Case #_____Year_____

Name:_____Phone:_____
(please print or type)

Signature:_____Date:_____

OR

(B.) I request waiver of the above requirement labeled "A", at the discretion of the sub-committee, and hereby certify, and provide proof, that I have completed an advanced course of instruction in trial advocacy.

Name:_____Phone:_____
(please print or type)

Signature:_____Date:_____

OVER:

AGREEMENT:

I hereby certify that I (and/or my firm) have affiliations with the following medical physicians and institutions.

Name: _____

Name: _____

Name: _____

AND

I hereby certify that I will attend or conduct no less than two (2) one hour sessions in each calendar year of continuing professional education in the area of Medical and Dental Malpractice or Personal Injury.

Name: _____ Phone: _____

Signature: _____ Date: _____

AND

I understand and agree that of the fees I receive as a result of a matter referred to me through the Lawyer Referral Service Medical/Dental Malpractice Experience Panel, 15% of gross fees earned over \$200 will be remitted to the LRS within 30 days of receipt.

Name: _____ Phone: _____
(please print or type)

Signature: _____ Date: _____

Please enclose the \$50 panel fee with the completed application.