

FLORIDA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM FILE# M80-2000-12

PRIMARY CARRIER

Company Code 44050 (Florida Certificate of Authority Number)

00339

Company Name PHYSICIANS PROTECTIVE TRUST FUND

Policy Number 3533

EXCESS CARRIER

Company Code (Florida Certificate of Authority Number)

Company Name _____

Policy Number _____

Calendar Year Claim Closed 82 FCC MMI IAC 3

Insured John Acevedo, M.D.

Address 600 S.W. 3rd St., Pompano Beach, FL

County Code 170

1) Speciality Anesthesiology Code 01

2) Date of Incident (Month, Day, Year) 050980

3) Date submitted for mediation (Month, Day, Year)

4) Disposition of mediation (check one):

(1) Plaintiff (2) Defendant (3) No final conclusion

5) Date of suit, if filed (Month, Day, Year)

6) Disposition of incident (check one):

(1) Final Judgment (2) Settlement

(3) Final Disposition Not Resulting in Payment on Behalf of the Insured

7) Date and amount of Judgment or Settlement (Month, Day, Year)

A. Primary Indemnity \$ 0 C. Excess Indemnity \$ _____

B. Primary Defense \$ 158. D. Excess Defense Costs \$ _____

8) Summary Judgment (1) For Plaintiff (2) For Defendant

9) Directed Verdict (1) For Plaintiff (2) For Defendant

10) Trial (1) YES (2) NO

11) Date and reason for final disposition, if no settlement or judgment:

(Month, Day, Year) 102882 STATUTE RAN-NO FURTHER ACTIVITY BY PLNTF.

12) Include brief summary of occurrence which created claim on back.

PERFORATION OF ESOPHAGUS