

FLORIDA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM

01496
B82-5501-81

File #

PRIMARY CARRIER

Company Code 04160 (Florida Certificate of Authority Number)

GI

Company Name FLORIDA PHYSICIANS' INSURANCE RECIPROCAL

Policy Number 8201-16417

EXCESS CARRIER

Company Code (Florida Certificate of Authority Number)

Company Name N/A

Policy Number

Calendar Year Claim Closed 83 FCC MM1 IAC 3

Insured Sheldon A. Roen, M.D.

Address 4300 Alton Rd., Miami Beach, Fl. 33140

County Code 011

(1) Specialty Radiology Code 20

(2) Date of Incident (Month, Day, Year) 070681

(3) Date submitted for mediation (Month, Day, Year) N/A

(4) Disposition of mediation (check one):

(1) Plaintiff (2) Defendant (3) No final conclusion N/A

(5) Date of suit, if filed (Month, Day, Year) 030482

(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 \$ 11,210.00 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) 012783 dismissed

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

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OCCURRENCE WHICH RESULTED IN CLAIM:

Patient admitted by another doctor. Insured performed arteriogram and angioplasty. Complication impaired blood supply to leg & foot dropped. Other doctor performed bypass, fasciotomy, debridement & antibiotic therapy but patient did not improve. Leg had to be amputated. Now suit has been filed alleging negligence.