FLORIDA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM

FILE# 82-3710-001

PRIMARY CARRIER

Company Code [4][4][0][5][0] (Florida Certificate of Authority Number) 4SU1155

Company Name PHYSICIANS PROTECTIVE TRUST FUND

Policy Number 2842

EXCESS CARRIER

Company Code [ ][ ][ ][ ][ ] (Florida Certificate of Authority Number)

Company Name _____

Policy Number _____

Calendar Year Claim Closed [8][5] FCC [ ][ ][ ] IAC [ ]

Insured Robert A. Buchholz, M.D.

Address Suite 2, 3660 Central Ave., Ft. Myers, FL 33901 County Code [1][8]

(1) Surgery Code [1] Speciality Psychiatrist Code [1][9]

(2) Date of Incident (Month, Day Year) [0][6][1][9][8][0]

(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) [0][5][0][4][8][2]

(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) [0][8][1][2][8][5]

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

B. Primary Defense $4726 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) [ ][ ][ ][ ][ ][ ] _____

_____

(12) Include brief summary of occurrence which created claim on back.
Patient alleges she was hospitalized against her wishes

Form No. DI4-303 Prepared by Dian L. McKinnon