FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. 8601712
INSURER'S CLAIM NO. ______

1. PRIMARY INSURER NAME: St. Paul Fire & Marine — INSURER CODE: 01470 (See Table

2. EXCESS INSURER NAME: ______ INSURER CODE: ______ (See Table

3. INSURED'S NAME: FREMAN, Alfred E. ~~Freeman M.D.~~
(Last Name, First and Middle Name)

STREET ADDRESS: 1807 S. Highland Ave.

CITY, STATE: Clearwater, Fl. ZIP: 33516 COUNTY CODE: 04 (See Table I

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	509JH6546	$1,000,000.00	$3,000,000.00
EXCESS INSURER :		$	$

5. Is the insured physician a Foreign Medical Graduate? If yes, enter the country in which primary medical educati was received: ______
- __ (01) Yes
- ✓ (02) No

6. PROFESSION OR BUSINESS: (Check one)
- ✓ (01) Physicians & Surgeons
- __ (02) Hospitals
- __ (03) Podiatrists
- __ (04) Other Medical Professionals
- __ (05) Clinics
- __ (06) Ambulatory Surgical Centers
- __ (07) Other Health Care Facilit

7. SPECIALTY CODE: 80249 (See Table C) (Applies to physicians, surgeons, and other health care professionals. Use ISO Common Statistical Base Classification Codes.)

8. BOARD CERTIFICATION: (Check one)
- ✓ (01) In specialty coded in Item 7, above.
- __ (02) In a different specialty.
- __ (03) In the specialty in Item 7 and another specialty. Enter the additional specialty code here: ______ (Table C,
- __ (04) Insured is not board certified.

9. PLACE WHERE INJURY OCCURRED: (Check one)
- __ (01) Hospital Inpatient Facility
- __ (02) Emergency Room
- __ (03) Hospital Outpatient Facility
- __ (04) Nursing Home
- __ (05) Physician's Office
- __ (06) Patient's Home
- __ (07) Other Outpatient Facility
- ✓ (08) Other Location
- __ (09) Other Hospital/Institution

10. If Place of Injury (above) is checked as (8) Other, then provide a description of the place where the injury occurred: Pinellas County Jail

11. NAME OF INSTITUTION: ______ INSTITUTION CODE: ______ (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)
- __ (01) Patient's Room
- __ (02) Operating Suite
- __ (03) Recovery Room
- __ (04) Labor & Delivery Room
- __ (05) Physical Therapy Dept.
- __ (06) Nursery
- __ (07) Critical Care Unit
- __ (08) Special Procedure Room
- __ (09) Radiology
- __ (10) Emergency Room

DI4-303 - Amended (08-86)

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13. DATE OF OCCURRENCE: 6/22/83

DATE REPORTED TO INSURER: 10/9/85

14. INJURED PERSON'S AGE: 23 Years (If less than one year, then enter 01)

INJURED PERSON'S SEX: (M) F (Circle one)

14.1 INJURED PERSON'S NAME:

	(LEAVE BLANK)
15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: psychiatric evaluation	15.
16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: NA	16.
17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: alleged failure to have patient transferred to a psychiatric facility.	17.
18. DESCRIBE THE OPERATION, DIAGNOSTIC OR TREATMENT PROCEDURE CAUSING THE INJURY. USE NOMENCLATURE AND/OR DESCRIPTIONS OF THE PROCEDURES USED. INCLUDE METHOD OF ANESTHESIA, OR NAME OF DRUG USED FOR TREATMENT, WITH DETAIL OF ADMINISTRATION: NA	18.
19. DESCRIBE THE PRINCIPAL INJURY GIVING RISE TO THE CLAIM. USE NOMENCLATURE AND/OR DESCRIPTIONS OF THE INJURY. INCLUDE TYPE OF ADVERSE EFFECT FROM DRUGS WHERE APPLICABLE: Gunshot wounds when c/mt. tried to escape	19.

20. SEVERITY OF INJURY: (check only one -- rate most serious injury if several are involved.)

___(01) Emotional only - Fright, no physical damage.

Temporary
___(02) Insignificant - Lacerations, contusions, minor scars, rash. No delay.
___(03) Minor - - - - - Infections, misset fracture, fall in hospital. Recovery delayed.
___(04) Major - - - - - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
✓(05) Minor - - - - - Loss of fingers, loss or damage to organs. Includes nondisabling injuries.

Permanent
___(06) Significant - - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
___(07) Major - - - - - Paraplegia, blindness, loss of two limbs, brain damage.
___(08) Grave - - - - - Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
___(09) Death

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21. DATE OF SUIT, IF ANY: 10/1/85

22. LIST OTHER DEFENDANTS INVOLVED IN THIS CLAIM, THE INSURER'S NUMBER AND THE COMPANION CLAIM FILE ID NUMBER:

	DEFENDANT'S NAME (Last Name, First Name)	INSURER CODE NO.	INSURER FILE ID.
1)			
2)			
3)			
4)			
5)			

23. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (Check one)
✓(01) Yes ___(02) No

24. DATE OF FINAL CLAIM DISPOSITION: 9/16/86

25. FINAL METHOD OF CLAIM DISPOSITION:
___(01) Settled by parties.
✓(02) Disposed of by a court.
___(03) Disposed of by arbitration.

26. SETTLEMENT: (Check one)
___(01) Within the presuit period as set forth in Section 768.57, Florida Statute (usually within 90 days).
___(02) After arbitration is initiated or prior to suit being filed.
___(03) Within 90 days of suit being filed.
✓(04) More than 90 days after suit is filed and prior to or during the course of mandatory settlement conference.
___(05) Prior to completion of the swearing of the jury.
___(06) Prior to filing of the notice of appeal.
___(07) After notice of appeal is filed or post-judgment relief or action is required for recovery.
___(08) During appeal.
___(09) After appeal.
___(10) Claim or suit abandoned.

27. COURT: (Check one)
___(01) No court proceedings.
___(02) Directed verdict for plaintiff.
✓(03) Directed verdict for defendant.
___(04) Judgment notwithstanding the verdict for the plaintiff.
___(05) Judgment notwithstanding the verdict for the defendant.
___(06) Judgment for the plaintiff.
___(07) Judgment for the defendant.
___(08) Judgment for the plaintiff after appeal.
___(09) Judgment for the defendant after appeal.
___(10) Other.
___(11) Summary judgment for the plaintiff.
___(12) Summary judgment for the defendant.

28. ARBITRATION: (Check one)
✓(01) Claim not subject to arbitration.
___(02) Claim subject to arbitration, but previously coded disposition reached in lieu of award.
___(03) Award for plaintiff.
___(04) Award for defendant.

29. WAS THERE AN ITEMIZED VERDICT UNDER FLORIDA STATUTE 768.48? (Check one)
___(01) Yes ✓(02) No (If yes, please attach copy of settlement or verdict.)

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30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - - - - - - - - - - - - $ 0

31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: - - - - - - - - $ 0

32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: - - - - - - - - - - - - $ 2574

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - - - - - - - - - - - - - - - - $ 1075

34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: - - - - - - - - 0

35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: - - - - - - 0

36. INJURED PERSON'S GROSS WEEKLY INCOME: - - - - - - - - - - - - - - - - - $ 0

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE	$ .00	$ .00	$ .00
B) ESTIMATED FUTURE	$ .00	$ .00	$ .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: - - - - - - - - - - - $ 0

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:

A) PRESENT VALUE OF PERIODIC PAYMENTS - - - - - - - - - - - - - - - - - - $ 0

B) COST TO THE INSURER OF THE PAYMENTS - - - - - - - - - - - - - - - - - $ 0

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - - - - - - - - - - - - - - - - - $ 0

D) DID YOU PURCHASE AN ANNUITY? ___ (01) Yes ✓ (02) No

40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: N/A

41. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: N/A

CONTACT PERSON: Ray Sultenfuss ADDRESS P.O. Box 22826
TELEPHONE: (813) 879 6154 Tampa, Fl 33622