FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. 8704383
INSURER'S CLAIM NO. 884-7537-8

1. **PRIMARY INSURER NAME:** FLORIDA PHYSICIANS INSURANCE COMPANY **INSURER CODE:** 0 4 1 6 0 (See Table A)

2. **EXCESS INSURER NAME:** _____ **INSURER CODE:** _____ (See Table A)

3. **INSURED'S NAME:** Dugan Charles C. (Last Name, First and Middle Name)

STREET ADDRESS: 2600 Broadway

CITY, STATE: West Palm Beach, FL **ZIP:** 33407 **COUNTY CODE:** 06 (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	8401-07848	$ 500,000.00	$ .00
EXCESS INSURER :		$	$

5. Is the insured physician a **Foreign Medical Graduate?** If yes, enter the **country** in which primary medical education 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 Facilities

7. **SPECIALTY CODE:** 80256 (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: _____

11. NAME OF INSTITUTION: N/A **INSTITUTION CODE:** _____ (See Table D)

12. **LOCATION OF INSTITUTIONAL INJURY:** (Check one)

- ___ (01) Patient's Room
- ___ (02) Operating Suite
- ___ (03) Recovery Room
- N/A
- ___ (04) Labor & Delivery Room
- ___ (05) Physical Therapy Dept.
- ___ (06) Nursery
- ___ (07) Critical Care Unit
- ___ (08) Special Procedure Room
- ___ (09) Radiology
- ___ (10) Emergency Room

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13. **DATE OF OCCURRENCE:** 7,2,81

DATE REPORTED TO INSURER: 1,19,84

14. **INJURED PERSON'S AGE:** 29 Years (If less than one year, then enter 01)

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

14.1 **INJURED PERSON'S NAME:** ___ _____ — _____
First and Middle Initial

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: (LEAVE BLANK) 15.
Severe facial acne

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: 16.
None

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: 17.
Use of Silicone caused minor burns

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: 18.
Silicone injections on face

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: 19.
Burns

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:** 3,19,84

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)	U/K		
2)			
3)			
4)			
5)			

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

24. **DATE OF FINAL CLAIM DISPOSITION:** 10/16/87

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 .00

31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: - - - - - - - - - - - - - - - - - - $ 0 .00

32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: - $ 8,206 - .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - $ 1,630 - .00

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

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

36. INJURED PERSON'S GROSS WEEKLY INCOME: - $ 0 .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE - - - -	$ 0 .00	$ 0 .00	$ 0 .00
B) ESTIMATED FUTURE - - - -	$ 0 .00	$ 0 .00	$ 0 .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: - $ 0 .00

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

A) PRESENT VALUE OF PERIODIC PAYMENTS - $ 0 .00

B) COST TO THE INSURER OF THE PAYMENTS - $ 0 .00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - $ 0 .00

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

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