



DEC 8 1987

FLORIDA DEPARTMENT OF INSURANCE  
FLORIDA MEDICAL PROFESSIONAL LIABILITY  
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. 8704623  
INSURER'S CLAIM NO. 509JP1340 09C 300

1. PRIMARY INSURER NAME: BUREAU OF KATES ST. Paul Insurance Co. INSURER CODE: 01470  
(See Table A)  
2. EXCESS INSURER NAME: N/A. INSURER CODE: \_\_\_\_\_  
(See Table A)  
3. INSURED'S NAME: Radin, Robert V.  
(Last Name, First and Middle Name)  
STREET ADDRESS: 3619 20TH ST.  
CITY, STATE: Vero Beach, Fla ZIP: 32960 COUNTY CODE: 03  
(See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>509JP1340</u>	<u>\$ 1,000,000.00</u>	<u>\$ 3,000,000.00</u>
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: 80102 (Applies to physicians, surgeons, and other health care professionals.  
(See Table C) 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: N/A

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  
 (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: 9, 28, 86

DATE REPORTED TO INSURER: 11, 11, 86

14. INJURED PERSON'S AGE: 4 Years (If less than one year, then enter 01)

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

14.1 INJURED PERSON'S NAME: \_\_\_\_\_ , \_\_\_\_\_  
Last name First and Middle Initial

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: Depressed Skull Fracture. (LEAVE BLANK)  
 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: Failed to diagnose the fracture  
 16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: Failed to diagnose skull fracture  
 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: See above  
 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: See above  
 19.

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

- (01) Emotional only - Fright, no physical damage.
- \_\_\_ (02) Insignificant - Lacerations, contusions, minor scars, rash. No delay.
- Temp- \_\_\_ (03) Minor - Infections, misset fracture, fall in hospital. Recovery delayed.
- orary \_\_\_ (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.
- Perma- \_\_\_ (06) Significant - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
- nent \_\_\_ (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:       /      /      

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

	<u>DEFENDANT'S NAME (Last Name, First Name)</u>	<u>INSURER CODE NO.</u>	<u>INSURER FILE ID.</u>
1)	<del>_____</del>	_____	_____
2)	<del>_____</del>	_____	_____
3)	<del>_____</del>	_____	_____
4)	<del>_____</del>	_____	_____
5)	<del>_____</del>	_____	_____

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

24. DATE OF FINAL CLAIM DISPOSITION: 11/17/87

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 Seciton 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)

<input checked="" type="checkbox"/> (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.
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28. ARBITRATION: (Check one)

<input checked="" type="checkbox"/> (01) Claim not subject to arbitration. <input checked="" type="checkbox"/> (02) Claim subject to arbitration, but previously coded disposition reached in lieu of award.	___(03) Award for plaintiff. ___(04) Award for defendant.
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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:-----\$                     .00
31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT:-----\$                     .00
32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL:-----\$                     .00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID:-----\$                     .00
34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE:-----                      days
35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS:-----                      days
36. INJURED PERSON'S GROSS WEEKLY INCOME:-----\$                     .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
A) INCURRED TO DATE-----\$	<u>                    </u> .00	\$ <u>                    </u> .00	\$ <u>                    </u> .00
B) ESTIMATED FUTURE-----\$	<u>                    </u> .00	\$ <u>                    </u> .00	\$ <u>                    </u> .00

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

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:
- A) PRESENT VALUE OF PERIODIC PAYMENTS-----\$                     .00
- B) COST TO THE INSURER OF THE PAYMENTS-----\$                     .00
- C) TOTAL EXPECTED PAYMENT TO PLAINTIFF-----\$                     .00
- D) DID YOU PURCHASE AN ANNUITY? \_\_\_(01) Yes \_\_\_(02) No

40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED:\_\_\_\_\_

\_\_\_\_\_

*No claim made -*

\_\_\_\_\_

\_\_\_\_\_

41. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY:\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CONTACT PERSON: R.L. FAGLEY ADDRESS: PO Box 31826  
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