

FLORIDA DEPARTMENT OF INSURANCE  
 FLORIDA MEDICAL PROFESSIONAL LIABILITY  
 INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. 8704708  
 INSURER'S CLAIM NO. 268303-001

1. PRIMARY INSURER NAME: PHYSICIANS PROTECTIVE TRUST FUND INSURER CODE: 44050  
 (See Table A)  
 2. EXCESS INSURER NAME: N/A INSURER CODE: N/A  
 (See Table A)  
 3. INSURED'S NAME: Punyani, Sat P.  
 (Last Name, First and Middle Name)  
 STREET ADDRESS: Memorial Hospital - E.R.  
3501 Johnson Street  
 CITY, STATE: Cooper City Florida ZIP: 33021 COUNTY CODE: 110  
 (See Table B)

4. POLICY NUMBER PER CLAIM POLICY LIMITS AGGREGATE POLICY LIMITS  
 PRIMARY INSURER: 0218900 \$ 1,000,000.00 \$ 3,000,000.00  
 EXCESS INSURER: N/A \$ N/A \$ N/A

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 - UNKNOWN UNKNOWN

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

7. SPECIALTY CODE: 801102 (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: N/A  
 \_\_\_ (04) Insured is not board certified. (Table C)

9. PLACE WHERE INJURY OCCURRED: (Check one)  
 \_\_\_ (01) Hospital Inpatient Facility \_\_\_ (04) Nursing Home \_\_\_ (07) Other Outpatient Facility  
 (02) Emergency Room \_\_\_ (05) Physician's Office \_\_\_ (08) Other Location  
 \_\_\_ (03) Hospital Outpatient Facility \_\_\_ (06) Patient's Home \_\_\_ (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: Memorial Hospital, Hollywood INSTITUTION CODE: 100030  
 (See Table D)

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

FLORIDA DEPARTMENT OF INSURANCE  
 FLORIDA MEDICAL PROFESSIONAL LIABILITY  
 INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. \_\_\_\_\_  
 INSURER'S CLAIM NO. 86-8303-001

1. DATE OF OCCURRENCE: 09/05/85  
 DATE REPORTED TO INSURER: 08/21/86  
 INJURED PERSON'S AGE: 53 Years (If less than one year, then enter 01)  
 INJURED PERSON'S SEX: M  (Circle one)

1.1 INJURED PERSON'S NAME: \_\_\_\_\_  
 Last Name First and Middle Initial

3. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED:	(LEAVE BLANK)
<u>Fever Chills and headache</u>	15.
4. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:	16.
<u>N/A</u>	
5. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:	17.
<u>Patient alleges that she had an allergic reaction to Aminophyllin which required hospitalization</u>	
6. 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.
<u>Doctor treated patient with bronchodilators for S.O.B., Aminophyllin 90 mg and theophylline 10. She was later sent home by another doctor with theodor and erythromycin</u>	
7. 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.
<u>Patient alleges reaction of rash and swelling was caused by allergic reaction to aminophyllin, however she was still being treated with theodor (an aminophyllin derivative without reaction) Patient unable to pay her medical bills</u>	

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.

rary  (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

FLORIDA DEPARTMENT OF INSURANCE  
 FLORIDA MEDICAL PROFESSIONAL LIABILITY  
 INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. \_\_\_\_\_  
 INSURER'S CLAIM NO. 86-2303-001

21. DATE OF SUIT, IF ANY: N/A / \_\_\_ / \_\_\_

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) <u>N/A</u>	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

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

24. DATE OF FINAL CLAIM DISPOSITION: 12/01/87

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.)

FLORIDA DEPARTMENT OF INSURANCE  
 FLORIDA MEDICAL PROFESSIONAL LIABILITY  
 INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. \_\_\_\_\_  
 INSURER'S CLAIM NO. 26-8308-001

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: ----- \$ 0.00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 05.00
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:

	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
A) INCURRED TO DATE - - - -	\$ <u>0.00</u>	\$ <u>0.00</u>	\$ <u>0.00</u>
B) ESTIMATED FUTURE - - - -	\$ <u>0.00</u>	\$ <u>0.00</u>	\$ <u>0.00</u>

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: Counseling

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CONTACT PERSON: Robert E. White Jr. ADDRESS P.O. Box 149001  
 TELEPHONE: (305) 442-4001 Coral Gables, Florida 33114