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FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

8801341

DEPARTMENT FILE NO.
INSURER'S CLAIM NO. 87-9447-023

1. PRIMARY INSURER NAME: Physicians Protective Trust Fund — INSURER CODE: 4 4 0 5 0 (See Table A)

2. EXCESS INSURER NAME: N/A — INSURER CODE: ______ (See Table A)

3. INSURED'S NAME: Mott, Mary S.
(Last Name, First and Middle Name)

STREET ADDRESS: P. O. Box 1659

CITY, STATE: Maitland, FL ZIP: 32751 COUNTY CODE: 1 7 (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	0191390	$ 500,000 .00	$ 1,500,000 .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
X (02) No

6. PROFESSION OR BUSINESS: (Check one)

X (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: 8 0 2 8 8 (See Table C) (Applies to physicians, surgeons, and other health care professionals. Use ISO Common Statistical Base Classification Codes.)

8. BOARD CERTIFICATION: (Check one)

X (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)

X (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: Winter Park Memorial Hospital — INSTITUTION CODE: 1 0 0 1 6 2 (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)

___ (01) Patient's Room
X (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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DATE OF OCCURRENCE: 06/ 04 85

DATE REPORTED TO INSURER: 06/ 19 87

INJURED PERSON'S AGE: 60 Years (If less than one year, then enter 01)

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

.1 INJURED PERSON'S NAME: ______ ______ ______
Last Name First and Middle Initial

	(LEAVE BLANK)
FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: Fluctuating sensory dysaesthesias, weakness and involuntary activity affecting the left upper extremity and left face.	15.
DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: NA	16.
DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: Myocardial infarction.	17.
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: Pt. underwent right carotid endarterectomy. During procedure, patient suffered a myocardial infarction.	18.
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: Coronary artery bypass surgery was required. Pt. recovered with no complications.	19.

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.
X (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: __/N/A/__

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)	N/A		
2)			
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 03/31/88

25. FINAL METHOD OF CLAIM DISPOSITION:
X (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.
X (10) Claim or suit abandoned.

27. COURT: (Check one)
X (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)
X (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 X (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: $ 0 .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: $ 0 .00

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

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

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

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

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

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

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

A) PRESENT VALUE OF PERIODIC PAYMENTS $ NA .00

B) COST TO THE INSURER OF THE PAYMENTS $ NA .00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF $ NA .00

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

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

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

CONTACT PERSON: Robert E. White
TELEPHONE: (305) 442-4001
ADDRESS: 2121 Ponce de Leon Blvd.
Coral Gables, FL 33114