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FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
CLOSED CLAIM REPORTING FORM

8803135
DEPT. FILE NO.

SEP 1 1988
BUREAU OF RATES

INSURER'S CLAIM NUMBER: 509JL4798 09B001

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

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

3a. HEALTH CARE PROVIDER: Cuervo, Mario Sula
(Last Name, First and Middle Name or Hospital Name from Table D)

3b. IF HEALTH CARE PROVIDER (above) IS A PHYSICIAN, DENTIST OR PODIATRIST ENTER DEPARTMENT OF PROFESSIONAL REGULATION LICENSE NUMBER: 0040730

3c. INSURED'S NAME: Mario Cuervo

STREET ADDRESS: 7500 S.W. 8th St.

CITY: Miami STATE: FL ZIP: 33144 COUNTY CODE: 01 (See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	509JL4798	$ 500,000 .00	$ 1,000,000 .00
EXCESS INSURER:	N/A	$ 0 .00	$ 0 .00

5. IS THE INSURED PHYSICIAN A FOREIGN MEDICAL GRADUATE? ___ (01) Yes X (02) No (If yes, enter the country in which primary medical education was received: N/A

6. PROFESSION OR BUSINESS: (Check one)
X (01) Physicians & Surgeons ___ (03) Podiatrists ___ (05) Abortion Clinics
___ (02) Hospitals ___ (04) Dentist ___ (06) Ambulatory Surgical Centers

7. SPECIALTY CODE: 80249 (See Table C) (Applies to physicians, surgeons, and dentists. 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. Enter the additional specialty code here:___
___ (04) Insured is not board certified. (See Table C)

9. PLACE WHERE INJURY OCCURRED: (Check one)
X (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 ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY OCCURRED: N/A

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11. NAME OF INSTITUTION: Harborview Hospital INSTITUTION CODE: 1,0,4,0,0,5 (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)

X (01) Patient's Room	___ (05) Physical Therapy Dept.	___ (09) Radiology
___ (02) Operating Suite	___ (06) Nursery	___ (10) Emergency Room
___ (03) Recovery Room	___ (07) Critical Care Unit	___ (11) Other _____
___ (04) Labor & Delivery Room	___ (08) Special Procedure Room	

13. DATE OF OCCURRENCE: 05/12/86

DATE REPORTED TO INSURER: 03/10/87

14. INJURED PERSON'S AGE: 75 Years (If less than one year, enter 00; if unknown, enter UNK.)

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

14.1 INJURED PERSON'S NAME: ___ Initial _____

STREET ADDRESS: ___

CITY: ___

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: alleged to have failed to diagnose & treat Fx hip (LEAVE BLANK) 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: alleged to have failed to diagnose fx hip 16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: alleged to have failed to diagnose & treat Fx hip 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 #17 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 #17 19.

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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 _X_(04) Major - - - - - Burns, surgical material left, drug side effect, brain damage. Recovery delaye

___(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

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

21.1 CIRCUIT COURT CASE NUMBER: N/A

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: N/A (SEE TABLE B)

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: 08/30/88

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

26. STAGE OF THE LEGAL SYSTEM AT WHICH SETTLEMENT WAS REACHED OR AWARD MADE: (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 filed and prior to or during the course of mandatory settlement conference.
___(05) During trial but before court verdict.
___(06) After court verdict and prior to filing of notice of appeal.
___(07) After notice of appeal is filed or post-judgement relief or action is required for recovery.
___(08) During appeal.
___(09) After appeal.
_X_(10) Claim or suit abandoned.

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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 plaintiff.
__ (05) Judgment notwithstanding the verdict for 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 settlement reached in lieu of award.
__ (03) Award for plaintiff.
__ (04) Award for defendant.

29. Was there an itemized verdict? (Check one)
__ (01) Yes X (02) No (If yes, please attach copy of settlement or verdict.)

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - $ 0 .00

30.1 AMOUNT OF DEDUCTIBLE PAID BY 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: - - - - - - - - - - - - - - - N/A days

35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: - - - - - - - - - - - - - N/A 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: N/A

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 X (02) No

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

41. TYPE OF NON-ECONOMIC DAMAGE LIMIT: (Check one)

___ (01) No limit (neither party requests or agrees to voluntary binding arbitration).
___ (02) No limit (defendant refuses claimant's offer of voluntary binding arbitration).
___ (03) $250,000 limit (both parties accept arbitration). (See Item 42 for exception.)
___ (04) $350,000 limit (plaintiff rejects arbitration).
X (05) Does not apply because occurrence happened before the 02-08-88 law.

42. IF (03) IS CHECKED IN ITEM 41 AND THE LIMIT ON NON-ECONOMIC DAMAGES IS DIFFERENT THAN $250,000, THEN INDICATE THE MODIFIED LIMIT: - $ 0 .00

43. COLLATERAL SOURCE INFORMATION: N/A
ENTER TO THE NEAREST PERCENT (use no decimals) THE PERCENT RECOVERY FOR ECONOMIC LOSS FROM:

A. ___% Health
B. ___% Disability
C. ___% Workers' Compensation
D. ___% Automobile
E. ___% Medicare, Medicaid & Social Security
F. ___% Other sources, specify: _____

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY:
none

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