POST MARKED

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

8803649
DEPT. FILE NO.

OCT 14 1988

INSURER'S CLAIM NUMBER: 509 JL 4798 098 002

BUREAU OF RATES

1. PRIMARY INSURER NAME: ST. PAUL FIRE & MARINE INS CO INSURER CODE: 04170 (See Table A)

2. EXCESS INSURER NAME: NONE INSURER CODE: (See Table A)

3a. HEALTH CARE PROVIDER: CUERVO MARIO C. (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 C CUERVO MD~~ SAME

STREET ADDRESS: 7500 S.W. 8TH ST, SUITE 204

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

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	509 JL 4798	$ 250,000.00	$ 750,000.00
EXCESS INSURER:	NONE	$ NONE .00	$ NONE .00

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

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

7. SPECIALTY CODE: 80235 (See Table C) (Applies to physicians, surgeons, and dentists. 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. Enter the additional specialty code here: ___ (See Table C)
___ (04) Insured is not board certified.

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 ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY OCCURRED: N/A

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11. NAME OF INSTITUTION: CEDARS HOSPITAL INSTITUTION CODE: 10,0009
(See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)

___ (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: 08/31/86

DATE REPORTED TO INSURER: 07/02/87

14. INJURED PERSON'S AGE: 89 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: H _____ Initial

STREET ADDRESS: ~

CITY: /

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: MAJOR DEPRESSION & MANIAC ILLNESS	(LEAVE BLANK) 15.	
16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: NONE	16.	
17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: ELECTROCONVULSIVE THERAPY (SHOCK TREATMENT) (ECT)	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: IT IS ALLEGED CLMT ALLOWED TO AMBULATE TO SOON AFTER ECT. FELL & FRACTURED HER HIP	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: FRACTURED HIP	19.	

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27. COURT: (Check one)

✓ (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)

✓ (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 ✓ (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: - $ 16,776 .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - $ 6774 .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 - - - -	$ .00	$ .00	$ 0 .00
B) ESTIMATED FUTURE - - - -	$ .00	$ .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

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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 ___(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

21. DATE OF SUIT, IF ANY: 5,31,88

21.1 CIRCUIT COURT CASE NUMBER: 87-47900

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 0,1 (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)	Cedars Medical Center	unk	unknown
2)	Florida Patients Compensation Fund	unk	unknow
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 9,29,88

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

40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: None

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).
✓ (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: - $________.00

43. COLLATERAL SOURCE INFORMATION:
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
No negligence

CONTACT PERSON: Lisa O'Connor ADDRESS P.O. 5807
TELEPHONE: (305) 485-2220 Ft. Lauderdale Fl. 3330

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL MALPRACTICE PROFESSIONAL
LIABILITY REPORTING FORM

GENERAL INSTRUCTIONS

Each self-insured hospital and ambulatory surgical center, each self-insurer authorized under s. 627.356 or s. 627.357 and each insurer or joint underwriting association providing professional liability insurance to a practitioner of medicine licensed pursuant to the provisions of chapter 458, to a practitioner of osteopathic medicine licensed pursuant to the provisions of chapter 459, to a podiatrist licensed pursuant to the provisions of chapter 461, to a dentist licensed pursuant to the provisions of chapter 466, to a hospital licensed pursuant to the provisions of chapter 395, to abortion clinics included in chapter 390 and to an ambulatory surgical center as defined in s. 395.002(2) shall report to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in:

a) A final judgement in any amount.
b) A settlement in any amount.
c) A final disposition not resulting in payment on behalf of the insured.

The legislature has recognized that the medical professional liability closed claim reporting form has two primary purposes. The original purpose is to collect statistical data on medical malpractice closed claims. The additional purpose, added in October 1, 1985, is to identify those physicians, podiatrist or dentist who may potentially be involved in conduct that is subject to disciplinary action. The latter function is being routed directly to the Department of Professional Regulation. Reports shall be filed with the Department of Insurance and, if the insured party is a practitioner of medicine, a practitioner of osteopathic medicine, a podiatrist, or a dentist, the claim report shall also be filed with the Department of Professional Regulation.

Reports shall be filed no later than sixty (60) days following the occurrence of any event listed in item a), b), or c) above. Submit a report for each individual practioner or hospital insured by the filing insurer, including claims closed without payment. Complete all items on the form. If the information is unknown, enter "UNK", if not applicable, enter "NA". When an item calls for a dollar amount and no amount is involved, enter 0 in the space after the $ sign. If a report is being prepared on a reopened case for which a previous report has been made, mark "previously reported" at the top of the first page of the report and next to it put the previously reported insurer claim number. Record all amounts in whole dollars, all dates as MMDDYY (example, 07/02/87), and all ages as the number of years old. Type or print clearly.