

POST MARKED

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

FEB 17 1988

8800584

DEPARTMENT FILE NO.
INSURER'S CLAIM NO. AK7-10258-R

BUREAU OF RATES

1. PRIMARY INSURER NAME: FLORIDA PHYSICIANS INSURANCE COMPANY INSURER CODE: 0,4,1,6,0
(See Table A)

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

3. INSURED'S NAME: Dugan Charles C.
(Last Name, First and Middle Name)

STREET ADDRESS: 2600 Broadway

CITY, STATE: West Palm Beach, FL ZIP: 33407 COUNTY CODE: 06
(See Table B)

4. POLICY NUMBER PER CLAIM POLICY LIMITS AGGREGATE POLICY LIMITS

PRIMARY INSURER: 8701-07848 \$ 500,000 .00 \$ _____ .00

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 (04) Other Medical Professionals (07) Other Health Care Facilities
 (02) Hospitals (05) Clinics
 (03) Podiatrists (06) Ambulatory Surgical Centers

7. SPECIALTY CODE: 80256 (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: _____
 (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. N/A 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: N/A INSTITUTION CODE: _____
(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
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DEPARTMENT FILE NO. _____
 INSURER'S CLAIM NO. 187-10658-87

13. DATE OF OCCURRENCE: 6,12,87
 DATE REPORTED TO INSURER: 7,22,87
 14. INJURED PERSON'S AGE: 30 Years (If less than one year, then enter 01)
 INJURED PERSON'S SEX: M F (Circle one)
 14.1 INJURED PERSON'S NAME: _____

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: <u>REMOVAL OF CYST FROM FACE</u>	(LEAVE BLANK) 15.
16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: <u>INADVERTENTLY USED ACID MIXED WITH ACETONE</u> <u>AND BURNED CT</u>	16.
17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: <u>BURNS</u>	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: <u>USED ACETONE & ACID ON PET. FACE</u>	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: <u>BURNS, SCARRING</u>	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

FLORIDA DEPARTMENT OF INSURANCE
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DEPARTMENT FILE NO. _____
 INSURER'S CLAIM NO. A87-10658-K


30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ----- \$ 5000. .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: ----- \$ 674. .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: ----- \$ _____ .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

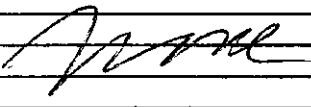
	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
A) INCURRED TO DATE -----	\$ <u>0</u> .00	\$ <u>0</u> .00	\$ <u>0</u> .00
B) ESTIMATED FUTURE -----	\$ <u>0</u> .00	\$ <u>0</u> .00	\$ <u>0</u> .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ 5000. .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: _____



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



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