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

9001276
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: A87-10530-85

1. PRIMARY INSURER NAME: Florida Physicians Insurance Company INSURER CODE: 0,9,5,8,3 (See Table A)

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

3a. HEALTH CARE PROVIDER: Mehta, Jitendra Uttamchand
(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: 0,0,3,4,1,2,8

3c. INSURED'S NAME: Same

STREET ADDRESS: 2127 Edgewater Drive, South East

CITY: Winter Haven STATE: FL ZIP: 33880 COUNTY CODE: 05 (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	8701-34128	$1,000,000.00	$3,000,000.00
EXCESS INSURER:	None	$ .00	$ .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: India IN

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: 8,0,2,4,9 (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: Transition House Winter Haven INSTITUTION CODE: UNK N/A (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	___

~~10~~ 00

13. DATE OF OCCURRENCE: 1/1/85

DATE REPORTED TO INSURER: 5/11/87

14. INJURED PERSON'S AGE: 33 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 NAM

STREET ADDRES

CIT

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: Suicide (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: Pt committed suicide 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: Dr was monitoring medications while pt was resident at TRANSITION House & being treated for long history of Major Depression AND Psychotic Features with Trilafon 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: Death Due to suicide 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 ___(04) Major - - - - - Burns, surgical material left, drug side effect, brain damage. Recovery delay

___(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: 10/22/87

21.1 CIRCUIT COURT CASE NUMBER: 87-1367

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 05 (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)	Winter Haven Hospital	unk	unk
2)	Transition House	unk	unk
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 3/19/90

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 conferenc
✓(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.

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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: - $ 35,000 .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: - $ 38,145 .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - $ 11,134 .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: - $ N/A .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

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

Compromise

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

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

A) PRESENT VALUE OF PERIODIC PAYMENTS - $ N/A .00

B) COST TO THE INSURER OF THE PAYMENTS - $ N/A .00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - $ N/A .00

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