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

9301275
DEPT. FILE NO.

BUREAU OF RATES F/O
FLA. DEPARTMENT OF INSURANCE

INSURER'S CLAIM NUMBER: 92-17-0003

1. PRIMARY INSURER NAME: Hospital Medical Staff Self Insurance Inc. INSURER CODE: 44037 (See Table A)

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

3a. HEALTH CARE PROVIDER: Martinez, Isaias R.
(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: 0051840

3c. INSURED'S NAME: Isaias Martinez

STREET ADDRESS: 1100 SW 96 Terrace

CITY: Pembroke Pines STATE: FL ZIP: 33025 COUNTY CODE: 10 (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	92-0372	$ 250,000 .00	$ 750,000 .00
EXCESS INSURER:	N/A	$ N/A .00	$ N/A .00

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

6. PROFESSION OR BUSINESS: (Check one)
- X (01) Physicians & Surgeons
- ___ (02) Hospitals
- ___ (03) Podiatrists
- ___ (04) Dentist
- ___ (05) Abortion Clinics
- ___ (06) Ambulatory Surgical Centers
- ___ (07) Crisis Stabilization Unit
- ___ (08) Health Maintenance Organization

7. SPECIALTY CODE: 80420 (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: _____
- X (04) Insured is not board certified. (See Table C)

9. PLACE WHERE INJURY OCCURRED: (Check one)
- ___ (01) Hospital Inpatient Facility
- ___ (02) Emergency Room
- ___ (03) Hospital Outpatient Facility
- ___ (04) Nursing Home
- X (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 ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY OCCURRED: N/A

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11. NAME OF INSTITUTION: N/A INSTITUTION CODE: N/A (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one) N/A

___ (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: 6/6/91

DATE REPORTED TO INSURER: 2/26/92

14. INJURED PERSON'S AGE: 39 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:

STREET ADDRESS:

CITY

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: myocardial infarctim

(LEAVE BLANK) 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: Delay in diagnosis of impending MI Alleged

16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: Pt. saw insured for chest pains. Diagnostic tests negative. Approximately one week later Pt. had MI.

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: N/A

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: Myocardial infarction

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 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

1. DATE OF SUIT, IF ANY: 6/2/93

1.1 CIRCUIT COURT CASE NUMBER: 93-14531(12)

1.2 COUNTY CODE OF COUNTY SUIT FILED IN: 10 (SEE TABLE B)

1. 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)	Melgen, Victor	44050	Unknown
2)	Century Medical Center, Inc.	44050	Unknown
3)			
4)			
5)			

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

. DATE OF FINAL CLAIM DISPOSITION: 6/30/93

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

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.
X(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.

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COURT: (Check one)

X (01)	No court proceedings.	___(07)	Judgment for the defendant.
___(02)	Directed verdict for plaintiff.	___(08)	Judgment for the plaintiff after appeal.
___(03)	Directed verdict for defendant.	___(09)	Judgment for the defendant after appeal.
___(04)	Judgment notwithstanding the verdict for plaintiff.	___(10)	Other
___(05)	Judgment notwithstanding the verdict for defendant.	___(11)	Summary judgment for the plaintiff.
___(06)	Judgment for the plaintiff.	___(12)	Summary judgment for the defendant.

ARBITRATION: (Check one)

X (01)	Claim not subject to arbitration.	___(03)	Award for plaintiff.
___(02)	Claim subject to arbitration, but settlement reached in lieu of award.	___(04)	Award for defendant.

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

INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - $ 35,000 .00

1 AMOUNT OF DEDUCTIBLE PAID BY THIS DEFENDANT: - $ 0.00

INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: - - - - - - - - - - - - - - - $ 0.00 N/A

LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: as of 6-22-93 - - - - - - - - - - - - - - $ 13,239.00

ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - $ 0.00

NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: - - - - - - - - - - - - - - - ____ days N/A

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

INJURED PERSON'S GROSS WEEKLY INCOME: - $ ____ .00 N/A

INJURED PERSON'S TOTAL ECONOMIC LOSS: N/A

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

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

IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM: N/A

A) PRESENT VALUE OF PERIODIC PAYMENTS - $ .00

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

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - $ .00

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

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

1. TYPE OF NON-ECONOMIC DAMAGE LIMIT: (Check one) N/A

___ (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.

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

. 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: _____

. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: Case discussed with physician; otherwise N/A

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