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

9301507
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 2244

1. PRIMARY INSURER NAME: FRONTIER INS. Co. of NEW YORK INSURER CODE: 0,9,5,7,4 (See Table A)

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

3a. HEALTH CARE PROVIDER: Garrido, Angel E.
(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: ME 4,2,0,5,2

3c. INSURED'S NAME: Miami Mental Health Center, Inc.

STREET ADDRESS: 2141 South west First Street

CITY: Miami STATE: FL ZIP: 3,3,1,3,5 COUNTY CODE: 0,1 (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	FPL 000032	$ 1,000,000.00	$ 3,000,000.00
EXCESS INSURER:	NONE	$ —.00	$ —.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: Dominican Republic DR

6. PROFESSION OR BUSINESS: (Check one)

X (01) Physicians & Surgeons	___ (04) Dentist	___ (07) Crisis Stabilization Unit
___ (02) Hospitals	___ (05) Abortion Clinics	___ (08) Health Maintenance Organization
___ (03) Podiatrists	___ (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: ___
X (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: Jackson Memorial INSTITUTION CODE: 1,0,0,0,2,2
(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: 05/03/91

DATE REPORTED TO INSURER: 02/18/93

14. INJURED PERSON'S AGE: 60 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: (LEAVE BLANK) 15.

Benzodiazepine dependance and abuse

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: 16.

N/A

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: 17.

Another patient attacked her causing additional stress and back pain, head trauma, two Altercations Altogether

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: 18.

N/A

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: 19.

Minor head trauma which lead to her transfer to another facility after 2nd Altercation

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20. SEVERITY OF INJURY: (check only one -- rate most serious injury if several are involved.)

X (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: ___/___/___ N/A

21.1 CIRCUIT COURT CASE NUMBER: N/A

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

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)			
2)	Jackson Memorial Hospital		
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 08/30/93

25. FINAL METHOD OF CLAIM DISPOSITION:
X (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).
X (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.

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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)

X (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: - $ N/A .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:
Insured was encouraged to provide adequate protection from patient altercations

CONTACT PERSON: Beverly McIntosh ADDRESS 195 LAKE LOUISE MARIE Rd.
TELEPHONE: (914) 796-2300 x-267 ROCK Hill, NY 12775-8000