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FLA. DEPARTMENT OF INSURANCE

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

9300909
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 87-10055-02-027

PRIMARY INSURER NAME: Physicians Protective Trust Fund INSURER CODE: 4 4 0 5 0 (See Table A)

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

HEALTH CARE PROVIDER: Alfonso, Israel
(Last Name, First and Middle Name or Hospital Name from Table D)

IF HEALTH CARE PROVIDER (above) IS A PHYSICIAN, DENTIST OR PODIATRIST ENTER DEPARTMENT OF PROFESSIONAL REGULATION LICENSE NUMBER: 0 0 3 3 1 6 4

INSURED'S NAME: same

STREET ADDRESS: 3200 S.W. 60th Court, Suite 302

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

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	M-0004500	$ 250,000.00	$ 750,000.00
EXCESS INSURER:	N/A	$ N/A .00	$ N/A .00

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: Spain SP

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

SPECIALTY CODE: 8 0 2 6 7 (See Table C) (Applies to physicians, surgeons, and dentists. Use ISO Common Statistical Base Classification Codes.)

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)
X (04) Insured is not board certified.

PLACE WHERE INJURY OCCURRED: (Check one)

X (01) Hospital Inpatient Facility
___ (02) Emergency Room
___ (03) Hospital Outpatient Facility
___ (04) Nursing Home
___ (05) Physician's Office
___ (06) Patient's Home
___ (07) Other Outpatient Facility
___ (08) Other Location
___ (09) Other Hospital/Institution

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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1. NAME OF INSTITUTION: Hialeah Hospital INSTITUTION CODE: 1 0 0 0 5 3
(See Table D)

2. LOCATION OF INSTITUTIONAL INJURY: (Check one)

___ (01) Patient's Room
___ (02) Operating Room
___ (03) Recovery Room
X (04) Labor & Delivery Room
___ (05) Physical Therapy Dept.
___ (06) Nursery
___ (07) Critical Care Unit
___ (08) Special Procedure Room
___ (09) Radiology
___ (10) Emergency Room
___ (11) Other _____

3. DATE OF OCCURRENCE: 12/28/85

DATE REPORTED TO INSURER: 11/30/87

4. INJURED PERSON'S AGE: 00 Years (If less than one year, enter 00; if unknown, enter UNK.)

INJURED PERSON'S SEX: M (F) (Circle one)

.1 INJURED PERSON'S NAME: _

STREET ADDRESS: _

CITY: _

5. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: (LEAVE BLANK)
Post natal consult for one infant with seizures treated with Phenobarbitol. 15.

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

7. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: 17.
Subsequent development of spastic quadriparesis and developmental delays.

8. 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.
Consultation requested after an emergency C-section on an 18-year-old eclamptic female and delivery of twin females.

9. 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.
See #17.

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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.
Temporary ___(03) Minor ------ Infections, missed fracture, fall in hospital. Recovery delayed.
___(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.
Permanent ___(06) Significant --- Deafness, loss of limb; loss of eye, loss of one kidney or lung.
X (07) Major ------ Paraplegia, blindness, loss of two limbs, brain damage.
___(08) Grave ------ Quadriplegia, severe brain damage, lifelong care or fatal prognosis.

___(09) Death

DATE OF SUIT, IF ANY: 06 / 23 / 88

1 CIRCUIT COURT CASE NUMBER: 88-6839 CA (05)

2 COUNTY CODE OF COUNTY SUIT FILED IN: 0 1 (SEE TABLE B)

LIST OTHER DEFENDANTS INVOLVED IN THIS CLAIM, THE INSURER'S NUMBER AND THE COMPANION CLAIM FILE TO NUMBER:

	DEFENDANT'S NAME (Last Name, First Name)	INSURER CODE NO.	INSURER FILE ID.
1)	HIALEAH HOSPITAL	SELF-INSURED	UNKNOWN
2)	JOSE M. PALOMINO, M.D.	44050	87-10055-01-027
3)	FRANCISCO G. TUDELA, M.D.	44030	UNKNOWN
4)	HIALEAH ANESTHESIA GROUP	44005	UNKNOWN
5)			

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

DATE OF FINAL CLAIM DISPOSITION: 05 / 03 / 93

FINAL METHOD OF CLAIM DISPOSITION: N/A Vol. Dismissal
___(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.
___(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.
X (10) Claims or suit abandoned.

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7. COURT: (Check one)

X (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.

8. ARBITRATION: (Check one)

X (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.

9. Was there an itemized verdict? (Check one)

___(01) Yes X (02) No (If yes, please attached copy of settlement verdict.)

10. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ---------- $ 0.00

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

11. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: ---------- $ 0.00

12. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: ---------- $ 81,002.00

13. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ---------- $ 31,182.00

14. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: ---------- $ 0 days

15. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: ---------- $ 0 days

16. INJURED PERSON'S GROSS WEEKLY INCOME: ---------- $ 0.00

17. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE	$ 380,000.00	$ 0.00	$ 0.00
B) ESTIMATED FUTURE	$ 700,000.00	$ 0.00	$ 0.00

18. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ---------- $ 0.00

19. 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 X (02) No

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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)

___(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).
X (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 N/A
$250,000, THEN INDICATE THE MODIFIED LIMIT: ---------- $_____.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: There was no testimony presented that Dr. Alfonso was negligent in any manner. The experts who reviewed the records felt timely and appropriate care and treatment were rendered.

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