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

9600909
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 94H03711

1. PRIMARY INSURER NAME: Frontier Insurance of Co ___ INSURER CODE: 09524 (See Table A)

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

3a. HEALTH CARE PROVIDER: Gutierrez, Luis Carlos Victor
(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: ~~80249~~ 29652

3c. INSURED'S NAME: Victor Gutierrez

STREET ADDRESS: 717 W. Martin Luther King Jr Blvd

CITY: Tampa STATE: FL ZIP: 33603 COUNTY CODE: 03 (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	F-KM-0009276-4/Occ	$ 1,000,000 .00	$3,000,000 .00
EXCESS INSURER:	N/A	$ .00	$ .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: Columbia CO

6. PROFESSION OR BUSINESS: (Check one)
- ✓ (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: 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
- ___ (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

10. IF PLACE OF INJURY (above) IS CHECKED AS ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY OCCURRED: n/a

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

NAME OF INSTITUTION: St. Joseph's Hospital INSTITUTION CODE: 1,0,0,0,7,7, (See Table D)

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	

DATE OF OCCURRENCE: 2/1/94

DATE REPORTED TO INSURER: 11/21/94

4. INJURED PERSON'S AGE: 85 Years (If less than one year, enter 00; if unknown, enter UNK.)

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

4.1 INJURED PERSON'S NAME: ___

STREET ADDRESS: ___

CITY: ___ 9,

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: (LEAVE BLANK)
Fracture of Right Hip — 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:
NONE — 16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:
Failure to institute adequate ~~bed restraints and~~ falling precautions to hospital staff due to confusion and the prescribing psychotropic medications — 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:
The prescribing of psychotropic medications which heightens confusion and the risk of fall — 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:
Fracture of Right Hip — 19.

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

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

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)	None		
2)			
3)			
4)			
5)			

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

24. DATE OF FINAL CLAIM DISPOSITION: 3/22/96

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)
X(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.
___(10) Claim or suit abandoned.

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

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: - $ 32,000 .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: - $ 104 .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - $ 2471 .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: - $ 0 .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE - - - -	$ 0 .00	$ 0 .00	$ 0 .00
B) ESTIMATED FUTURE - - - -	$ 0 .00	$ 0 .00	$ 0 .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: - - - - - - - - - - - - - - - - - - - $ 32,000 .00

39. 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

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

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).
- ___ (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:
ENTER TO THE NEAREST PERCENT (use no decimals) THE PERCENT RECOVERY FOR ECONOMIC LOSS FROM:

A. ___%	Health	D. ___%	Automobile
B. ___%	Disability	E. 100%	Medicare, Medicaid & Social Security
C. ___%	Workers' Compensation	F. ___%	Other sources, specify:

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: Phycian participated on a Risk Management Course

CONTACT PERSON: Deborah Crosby ADDRESS 6360 NW 5th Way, Suite 303
TELEPHONE: (305) 491-6078 Ft. Lauderdale, FL 33309