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

9700672
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 90-14699-01-027

1. PRIMARY INSURER NAME: PHYSICIANS PROTECTIVE TRUST FUND INSURER CODE: |4|4|0|5|0| (See Table A)

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

3a. HEALTH CARE PROVIDER: Rzadkowolsky, Anna
(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|4|5|6|9|2|

3c. INSURED'S NAME: Anna Rzadkowolsky, M.D.

STREET ADDRESS: 291 East 2nd Street

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

4.

| | POLICY NUMBER | PER CLAIM POLICY LIMITS | AGGREGATE POLICY LIMITS |
|---|---|---|---|
| PRIMARY INSURER: | M-1004938 | $ 250,000.00 | $ 750,000.00 |
| EXCESS INSURER: | N/A | $ 0.00 | $ 0.00 |

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: Poland

PO

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: |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)

X (01) In specialty code in Item 7, above.
___ (02) In a different specialty.
___ (03) In the specialty in Item 7 and another.
___ (04) Insured is not Board Certified.

Enter the additional specialty code here: _____ (see table C)

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
X (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:

The patient was in a neighbor's yard when the patient shot the neighbor.

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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 Room | ___ (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: 7 / 1 / 90

DATE REPORTED TO INSURER: 11 / 9 / 90

14. INJURED PERSON'S AGE: 13 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: ___ | 2 |

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: | (LEAVE BLANK) |
Atypical psychosis and conduct disorder.

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. |
The patient shot a neighbor while on a home pass from Montanari clinic.

18. DESCRIBE THE OPERATION, DIAGNOSTIC OR TREATMENT PROCEDURE CAUSING THE INJURY. USE NO MENCLATURE 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 THE INJURY. INCLUDE TYPE OF ADVERSE EFFECT FROM DRUGS WHERE APPLICABLE: | 19. |
Death.

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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, missed 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 non-disabling 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 - - - - - - Quadriplegia, severe brain damage, lifelong care or fatal prognosis.

__X__ (09) Death

21. DATE OF SUIT, IF ANY: 6 / 26 / 92

21.1 CIRCUIT COURT CASE NUMBER: 92-14592 CA 24

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

22. 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 NO. |
|---|---|---|---|
| 1) | Montanari Clinical School | Unknown | Unknown |
| 2) | | | |
| 3) | | | |
| 4) | | | |
| 5) | | | |

23. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (Check One)
__X__ (01) Yes ____ (02) No

24. DATE OF FINAL CLAIM DISPOSITION: 3 / 17 / 97

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 pre-suit 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.
__X__ (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 notice of appeal.
____ (07) After notice of appeal is filed or post-judgment relief or action is required for recovery.
____ (08) During appeal.
____ (09) After appeal.
____ (10) Claim or suit abandoned.

27. 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. |

28. 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. |

29. Was there an itemized verdict? (Check One)

____ (01) Yes X (02) No (If yes, please attach copy of settlement or verdict.)

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: $ 75,000.00

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: $ 54,678.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: $ 33,956.00

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: $ 75,000.00

39. 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)

__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-ECONOMICAL DAMAGES IS DIFFERENT THAN $250,000, THEN INDICATE THE MODIFIED LIMIT: ..... $ 0.00

43. COLLATERAL SOURCE INFORMATION:
ENTER TO THE NEAREST PERCENT (use no decimals) THE PERCENT RECOVERY FOR ECONOMIC LOSS FROM:

A. 0 % Health
B. 0 % *Disability*
C. 0 % Worker's Compensation
D. 0 % Automobile
E. 0 % *Medicare, Medicaid & Social Security*
F. 0 % Other sources, specify:

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURE TO MAKE SIMILAR OCCURRENCES LESS LIKELY:
Member discussed claim with insurance company personnel.

CONTACT PERSON: Fred Scheriff, Miami Regional Claims Manager
TELEPHONE: (305) 442-4001
ADDRESS: Physicians Protective Trust Fund
2121 Ponce de Leon Boulevard, Suite 350
Coral Gables, Florida 33134

**TM/mor:[#F]:PPTF:2607-3-57.SR:D/3-13**