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

9800680
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: 94-15447-02-027

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: Limperis, Nicholas Michael
(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|1|6|1|5|9|

3c. INSURED'S NAME: Nicholas M. Limperis, M.D.

STREET ADDRESS: 1900 East Commercial Boulevard

CITY: Ft. Lauderdale STATE: |F|L| ZIP: |3|3|3|0|8| COUNTY CODE: |1|0| (See Table B)

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	M-1002821	$ 250,000.00	$ 750,000.00
EXCESS INSURER:	N/A	$ 0.00	$ 0.00

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: N/A

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|6|7| (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)

_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

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: Holy Cross Hospital INSTITUTION CODE: | 1 | 0 | 0 | 0 | 7 | 3 | (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check One)

X	(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: 4 / 26 / 89

DATE REPORTED TO INSURER: 4 / 23 / 91

14. INJURED PERSON'S AGE: 01 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: STATE:

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

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:
No missed diagnosis alleged.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:
Intravenous therapy infiltrated into the left foot.

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:
Intravenous therapy for meningitis infiltrated into left foot causing tissue damage.

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:
Scarring of left foot.

(LEAVE BLANK)
15.
16.
17.
18.
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.

Temporary
____ (02) Insignificant - Lacerations, contusions, minor scars, rash. No delay.
____ (03) Minor - - - - - - Infections, missed fracture, fall in hospital. Recovery delayed.
____ (04) Major - - - - - - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.

Permanent
__X__ (05) Minor - - - - - - Loss of fingers, loss or damage to organs. Includes non-disabling injuries.
____ (06) Significant - - - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
____ (07) Major - - - - - - Paraplegia, blindness, loss of two limbs, brain damage.
____ (08) Grave - - - - - - Quadriplegia, severe brain damage, lifelong care or fatal prognosis.

____ (09) Death

21. DATE OF SUIT, IF ANY: 5 / 2 / 91

21.1 CIRCUIT COURT CASE NUMBER: 90-31776

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: | 1 | 0 | (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)	Bratt, Irving, M.D.	44050	91-15447-01-027
2)	Holy Cross Hospital	Unknown	Unknown
3)			
4)			
5)			

23. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (Check One)

__X__ (01) Yes ____ (02) No

24. DATE OF FINAL CLAIM DISPOSITION: 3 / 4 / 98

25. FINAL METHOD OF CLAIM DISPOSITION:

____ (01) Settled by parties.
__X__ (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.
____ (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.
__X__ (09) After appeal.
____ (10) Claim or suit abandoned.

27. COURT: (Check One)

____	(01)	No court proceedings.	__X__	(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: ..... $ 0.00

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: ..... $ 186,715.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ..... $ 98,168.00

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: ..... $ 0.00

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:
Review of allegations with experts and insurance company personnel.

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

LT/mor:*[#F]*:PPTF:2798-3-84.SR:D/3-3