

FLORIDA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM

82-02441

FILE# _____

PRIMARY CARRIER

Company Code 01470 (Florida Certificate of Authority Number)

Company Name St Paul Ins. Co

Policy Number 509 JH 6776 09 A001

EXCESS CARRIER

Company Code (Florida Certificate of Authority Number)

Company Name _____

Policy Number _____

Calendar Year Claim Closed 82 FCC FIM1 IAC 3

Insured Dr David Wilson Cheshire, M.D.

Address 35-99 University Blvd, Jacksonville FL County 02

(1) Speciality Psychiatry Code 119

(2) Date of Incident (Month, Day, Year) 03/19/82

(3) Date submitted for mediation (Month, Day, Year)

(4) Disposition of mediation (check one):
(1) Plaintiff (2) Defendant (3) No final conclusion

(5) Date of suit, if filed (Month, Day, Year)

(6) Disposition of incident (check one):
(1) Final Judgment (2) Settlement
(3) Final Disposition Not Resulting in Payment on Behalf of the Insured

(7) Date and amount of Judgment or Settlement (Month, Day, Year)

A. Primary Indemnity \$ _____ C. Excess Indemnity \$ _____
B. Primary Defense \$ _____ D. Excess Defense Costs \$ _____

(8) Summary Judgment (1) For Plaintiff (2) For Defendant

(9) Directed Verdict (1) For Plaintiff (2) For Defendant

(10) Trial (1) YES (2) NO

(11) Date and reason for final disposition, if no settlement or judgment:
(Month, Day, Year) 1/24/82 Claim denied - no claim

Improper diagnosis - drug related

(12) Include brief summary of occurrence which created claim on back.