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FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

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DEPARTMENT FILE NO. ______
INSURER'S CLAIM NO. 75-81

1. PRIMARY INSURER NAME: South Broward Hospital District Physician's Professional Liability Insurance Trust — INSURER CODE: 4 4 0 6 (See Table

2. EXCESS INSURER NAME: Florida Patient's Compensation Fund — INSURER CODE: 4 6 0 1 (See Table

3. INSURED'S NAME: Shawbitz, Michael, M.D.
(Last Name, First and Middle Name)

STREET ADDRESS: 1005 Mar-Walt Drive

CITY, STATE: FT. Walton Beac-h, Fl — ZIP: 32540 — COUNTY CODE: ~~UNK~~ 43 (See Table B

4.

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	417	$ 100,000 .00	$ NA .00
EXCESS INSURER :	9268	$ UNK	$ UNK

5. Is the insured physician a **Foreign Medical Graduate**? If yes, enter the **country** in which primary medical educati was received: ______
___ (01) Yes
_X_ (02) No

6. **PROFESSION OR BUSINESS:** (Check one)
_X_ (01) Physicians & Surgeons
___ (02) Hospitals
___ (03) Podiatrists
___ (04) Other Medical Professionals
___ (05) Clinics
___ (06) Ambulatory Surgical Centers
___ (07) Other Health Care Facili

7. **SPECIALTY CODE:** 8 0 2 5 7 (See Table C) (Applies to physicians, surgeons, and other health care professionals. 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 specialty. Enter the additional specialty code here: ______ (Table C
_X_ (04) Insured is not board certified.

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 Facilit
___ (08) Other Location
___ (09) Other Hospital/Instituti

10. If Place of Injury (above) is checked as (8) Other, then provide a description of the place where the injury occurred: ______

11. NAME OF INSTITUTION: Memorial Hospital Hollywood — INSTITUTION CODE: 1 0 0 0 (See Table

12. **LOCATION OF INSTITUTIONAL INJURY:** (Check one)
_X_ (01) Patient's Room
___ (02) Operating Suite
___ (03) Recovery Room
___ (04) Labor & Delivery Room
___ (05) Physical Therapy Dept.
___ (06) Nursery
___ (07) Critical Care Unit
___ (08) Special Procedure Room
___ (09) Radiology
___ (10) Emergency Room

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DATE OF OCCURRENCE: 10/20/81

DATE REPORTED TO INSURER: 03/11/82

INJURED PERSON'S AGE: 75 Years (If less than one year, then enter 01)

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

INJURED PERSON'S NAME: ______ ______
Last Name First and Middle Initial

(LEAVE BLANK)

FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED:
Stroke

15.

DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:
NA

16.

DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:
Alleged improper treatment

17.

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:
NA

18.

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:
Paralysis - loss of speach

19.

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, misset 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
X___(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 - - - - - Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
___(09) Death

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1. DATE OF SUIT, IF ANY: 09 / 09 / 83

2. 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)	Adams, Charles, M.D.	44060	75-81
2)	~~Rosenthal & Adams, M.D., P.A.~~	~~44060~~	~~75-81~~
3)			
4)			
5)			

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

4. DATE OF FINAL CLAIM DISPOSITION: 09 / 23 / 86

5. FINAL METHOD OF CLAIM DISPOSITION:
X (01) Settled by parties.
___(02) Disposed of by a court.
___(03) Disposed of by arbitration.

6. SETTLEMENT: (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.
X (04) More than 90 days after suit is filed and prior to or during the course of mandatory settlement conferen
___(05) Prior to completion of the swearing of the jury.
___(06) Prior to filing of the 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.

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 the plaintiff.
___(05) Judgment notwithstanding the verdict for the defendant.
___(06) Judgment for the plaintiff.
___(07) Judgment for the defendant.
___(08) Judgment for the plaintiff after appea
___(09) Judgment for the defendant after appea
___(10) Other.
___(11) Summary judgment for the plaintiff.
___(12) Summary judgment for the defendant.

8. ARBITRATION: (Check one) NA
___(01) Claim not subject to arbitration.
___(02) Claim subject to arbitration, but previously coded disposition reached in lieu of award.
___(03) Award for plaintiff.
___(04) Award for defendant.

9. WAS THERE AN ITEMIZED VERDICT UNDER FLORIDA STATUTE 768.48? (Check one)
___(01) Yes X (02) No (If yes, please attach copy of settlement or verdict.)

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30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - - - - - $ -0- .

31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: - - - - - $ -0- .

32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: - - - - - $ -0- .

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

34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: - - - - - NA

35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: - - - - - NA

36. INJURED PERSON'S GROSS WEEKLY INCOME: - - - - - $ NA .

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

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

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: - - - - - $ -0-

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:

A) PRESENT VALUE OF PERIODIC PAYMENTS - - - - - $ ______

B) COST TO THE INSURER OF THE PAYMENTS - - - - - $ ______

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - - - - - $ ______

D) DID YOU PURCHASE AN **ANNUITY**? ___ (01) Yes X (02) No

40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: ______

41. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: UNK

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