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FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

8701370

DEPARTMENT FILE NO.
INSURER'S CLAIM NO. FB-6859-80

JUN 2 1987

BUREAU OF RATES

1. PRIMARY INSURER NAME: FLORIDA PHYSICIANS INSURANCE COMPANY INSURER CODE: 04160
(See Table A)

2. EXCESS INSURER NAME: _____ INSURER CODE: _____
(See Table A)

3. INSURED'S NAME: Masco, M.D. Howard L.
(Last Name, First and Middle Name)

STREET ADDRESS: 1801 South Boulevard

CITY, STATE: New Port Richey, Fl. ZIP: 33552 COUNTY CODE: 28
(See Table B)

	<u>POLICY NUMBER</u>	<u>PER CLAIM POLICY LIMITS</u>	<u>AGGREGATE POLICY LIMITS</u>
4. PRIMARY INSURER:	<u>8301-19480</u>	<u>\$ 1,000,000.00</u>	<u>\$.00</u>
EXCESS INSURER :	_____	<u>\$ _____</u>	<u>\$ _____</u>

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

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

7. SPECIALTY CODE: 80.249 (Applies to physicians, surgeons, and other health care professionals.
(See Table C) 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: _____
 (04) Insured is not board certified. (Table C)

9. PLACE WHERE INJURY OCCURRED: (Check one)
 (01) Hospital Inpatient Facility (04) Nursing Home (07) Other Outpatient Facility
 (02) Emergency Room (05) Physician's Office (08) Other Location
 (03) Hospital Outpatient Facility (06) Patient's Home (09) Other Hospital/Institution

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: Northside Community Mental Health Center INSTITUTION CODE: 104023
(See Table D)

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

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 INSURER'S CLAIM NO. FR3-685982

13. DATE OF OCCURRENCE: 2,13,82
 DATE REPORTED TO INSURER: 3,17,83
 14. INJURED PERSON'S AGE: 28 Years (If less than one year, then enter 01)
 INJURED PERSON'S SEX: M F (Circle one)
 14.1 INJURED PERSON'S NAME: _____

First and middle names _____

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED:	(LEAVE BLANK)
<u>Chronic schizophrenia with suicide tendencies</u>	15.
16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: <u>NONE</u>	16.
17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: <u>After admission pt Attempted suicide</u>	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: <u>pt was admitted with suicide tendencies AND WAS NOT WATCHED by Hosp personnel, she attempted suicide by hanging herself in her room</u>	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: <u>Severe Brain Damage due to Hypoxia</u>	19.

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

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 INSURER'S CLAIM NO. A83-6855-81

30. INDEMNITY PAID BY YOU ON BEHALF OF 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: - - - - - \$ 54,505 .00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - - - - - \$ 27074 .00
34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: - - - - - _____ days
35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: - - - - - _____ days
36. INJURED PERSON'S GROSS WEEKLY INCOME: - - - - - \$ _____ .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS: MA

	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
A) INCURRED TO DATE - - - - -	\$ _____ .00	\$ _____ .00	\$ _____ .00
B) ESTIMATED FUTURE - - - - -	\$ _____ .00	\$ _____ .00	\$ _____ .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: - - - - - \$ _____ .00
39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:
- 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

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

N/A

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

N/A

CONTACT PERSON: W. D. [Signature] ADDRESS 1000 Riverside Avenue, P.O. Box 44033
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