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

9700158

DEPT. FILE NO.

BUREAU OF PROPERTY &
CASUALTY FORMS & RATES

INSURER'S CLAIM NUMBER: 95-22660-003

1. PRIMARY INSURER NAME: PHYSICIANS PROTECTIVE TRUST FUND INSURER CODE: 44015101
(See Table A)

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

3a. HEALTH CARE PROVIDER: Pages, Francisco Jose
(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: 101031611121

3c. INSURED'S NAME: Same as 3a.

STREET ADDRESS: 3055 Northwest 19th Street

CITY: Miami STATE: FL ZIP: 33112151 COUNTY CODE: 0111
(See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>M-1007992</u>	<u>\$ 250,000.00</u>	<u>\$ 750,000.00</u>
EXCESS INSURER:	<u>N/A</u>	<u>\$ 0.00</u>	<u>\$ 0.00</u>

5. IS THE INSURED PHYSICIAN A FOREIGN MEDICAL GRADUATE? (01) Yes (02) No (If yes, enter the Country
in which primary medical education was received: Costa Rica **CR**

6. PROFESSION OR BUSINESS: (Check One)

- (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: 1810214191 (Applies to physicians, surgeons, and dentists.
(See Table C) Use ISO Common Statistical Base Classification Codes.)

8. BOARD CERTIFICATION: (Check One)

- (01) In specialty code in Item 7, above.
- (02) In a different specialty.
- (03) In the specialty in Item 7 and another. Enter the additional specialty code here: N/A
- (04) Insured is not Board Certified. (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
- (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

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

11. NAME OF INSTITUTION: _____ N/A _____

INSTITUTION CODE: 19999999
(See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check One)

- | | | |
|-----------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> (01) Patient's Room | <input type="checkbox"/> (05) Physical Therapy Dept. | <input type="checkbox"/> (09) Radiology |
| <input type="checkbox"/> (02) Operating Room | <input type="checkbox"/> (06) Nursery | <input type="checkbox"/> (10) Emergency Room |
| <input type="checkbox"/> (03) Recovery Room | <input type="checkbox"/> (07) Critical Care Unit | <input checked="" type="checkbox"/> (11) Other: Nursing Home |
| <input type="checkbox"/> (04) Labor & Delivery Room | <input type="checkbox"/> (08) Special Procedure Room | |

13. DATE OF OCCURRENCE: 04/04/95

N/A

DATE REPORTED TO INSURER: 04/04/95

14. INJURED PERSON'S AGE: 80 Years (If less than one year, enter 00; if unknown, enter UNK.)

INJURED PERSON'S SEX: M (Circle One)

14.1 INJURED PERSON'S NAME: _____

STREET ADDRESS: _____

CITY: _____

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

(LEAVE BLANK)

Dislocated toe; left foot.

15.

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

N/A

16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:

The patient developed gangrene and had a below knee amputation. It is alleged that Dr. Pages failed to have the patient transferred to the hospital in a timely manner.

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:

N/A

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:

Gangrene with subsequent left below knee amputation.

19.

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

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 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 - - - - - Quadriplegia, severe brain damage, lifelong care or fatal prognosis.
- (09) Death

21. DATE OF SUIT, IF ANY: 04/ 16/ 96

21.1 CIRCUIT COURT CASE NUMBER: 96-00267 CA 04

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 1011 (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) <u>Fair Haven's Nursing Home</u>	<u>Unknown</u>	<u>09-1-42414</u>
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

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

24. DATE OF FINAL CLAIM DISPOSITION: 01/ 07/ 97

25. FINAL METHOD OF CLAIM DISPOSITION:

- (01) Settled by parties.
 - (02) Disposed of by a court.
 - (03) Disposed of by arbitration.
- N/A*

26. STAGE OF THE LEGAL SYSTEM AT WHICH SETTLEMENT WAS REACHED OR AWARD MADE: (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.
- (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.

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

27. COURT: (Check One)

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> (01) No court proceedings.
<input type="checkbox"/> (02) Directed verdict for plaintiff.
<input type="checkbox"/> (03) Directed verdict for defendant.
<input type="checkbox"/> (04) Judgment notwithstanding the verdict for plaintiff.
<input type="checkbox"/> (05) Judgment notwithstanding the verdict for defendant.
<input type="checkbox"/> (06) Judgment for the plaintiff. | <input type="checkbox"/> (07) Judgment for the defendant.
<input type="checkbox"/> (08) Judgment for the plaintiff after appeal.
<input type="checkbox"/> (09) Judgment for the defendant after appeal.
<input type="checkbox"/> (10) Other
<input type="checkbox"/> (11) Summary Judgment for the plaintiff.
<input type="checkbox"/> (12) Summary Judgment for the defendant. |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

28. ARBITRATION: (Check One)

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> (01) Claim not subject to arbitration.
<input type="checkbox"/> (02) Claim subject to arbitration, but settlement reached in lieu of award. | <input type="checkbox"/> (03) Award for plaintiff.
<input type="checkbox"/> (04) Award for defendant. |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|

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

- (01) Yes (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: \$ 6,354.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: \$ 7,232.00

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:

	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
A) INCURRED TO DATE . . .	\$ <u>0.00</u>	\$ <u>0.00</u>	\$ <u>0.00</u>
B) ESTIMATED FUTURE . . .	\$ <u>0.00</u>	\$ <u>0.00</u>	\$ <u>0.00</u>

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 | \$ <u>0.00</u> |
| B) COST TO THE INSURER OF THE PAYMENTS | \$ <u>0.00</u> |
| C) TOTAL EXPECTED PAYMENT TO PLAINTIFF | \$ <u>0.00</u> |
| D) DID YOU PURCHASE AN ANNUITY? <input type="checkbox"/> (01) Yes <input checked="" type="checkbox"/> (02) No | |

FLORIDA DEPARTMENT OF INSURANCE
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CLOSED CLAIM REPORTING FORM

40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: N/A

41. TYPE OF NON-ECONOMIC DAMAGE LIMIT: (Check One)

- (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. <u>0</u> % Health | D. <u>0</u> % Automobile |
| B. <u>0</u> % Disability | E. <u>0</u> % Medicare, Medicaid & Social Security |
| C. <u>0</u> % Worker's Compensation | F. <u>0</u> % Other sources, specify: _____ |

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURE TO MAKE SIMILAR OCCURRENCES LESS LIKELY: _____
Member discussed claim with insurance company personnel, defense counsel and medical experts.

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

SG/bp: /#10):PPTF:3816-1-26.SR:D/1-6