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

9703023

DEPT. FILE NO.

DEC 29 1997

INSURER'S CLAIM NUMBER: 91-0348-105

BUREAU OF PROPERTY  
CASUALTY FORMS & RATES

1. PRIMARY INSURER NAME: Legion Insurance Company INSURER CODE: 09387  
(See Table A)

2. EXCESS INSURER NAME: NA INSURER CODE: \_\_\_\_\_  
(See Table A)

3a. HEALTH CARE PROVIDER: Porter, Dennis Ray  
(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: 00053424

3c. INSURED'S NAME: Dennis R. Porter

STREET ADDRESS: 21301 Powerline Rd. #104

CITY: Boca Raton STATE: FL ZIP: 33433 COUNTY CODE: 06  
(See Table B)

	<u>POLICY NUMBER</u>	<u>PER CLAIM POLICY LIMITS</u>	<u>AGGREGATE POLICY LIMITS</u>
PRIMARY INSURER:	<u>GL3000001</u>	<u>\$ 1,000,000.00</u>	<u>\$ 3,000,000.00</u>
EXCESS INSURER:	<u>NA</u>	<u>\$ .00</u>	<u>\$ .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: \_\_\_\_\_)

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: 810116 (Applies to physicians, surgeons, and dentists. Use ISO Common Statistical Base Classification Codes.)  
(See Table C)

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. Enter the additional specialty code here: \_\_\_\_\_
  - (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: \_\_\_\_\_

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11. NAME OF INSTITUTION: Fair Oaks Hospital INSTITUTION CODE: 11,0,0,0,2  
(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 Suite	<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 type="checkbox"/> (11) Other _____
<input type="checkbox"/> (04) Labor & Delivery Room	<input type="checkbox"/> (08) Special Procedure Room	

13. DATE OF OCCURRENCE: 11, 29, 91

DATE REPORTED TO INSURER: 9, 14, 93

14. INJURED PERSON'S AGE: 7 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: \_\_\_\_\_

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: Hallucinations, hyperactivity (LEAVE BLANK) 15.

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

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: 7yo was admitted without consent/proper authorization of parent. 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: Unnecessary tests & medications were given without permission of parent. (Lithium, Navane, & Desipramine) 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: Allegations of unnecessary confinement 19.



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

28. ARBITRATION: (Check one)
- |   |  |
|---|--|
| <input type="checkbox"/> (01) Claim not subject to arbitration.<br><input type="checkbox"/> (02) Claim subject to arbitration, but settlement reached in lieu of award. | <input type="checkbox"/> (03) Award for plaintiff.<br><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: ----- \$ 120,000.00

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: ----- \$ 46,984.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 0.00

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: NA

	<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: ----- \$ NA.00

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

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?     (01) Yes     (02) No

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

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

(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-ECONOMIC DAMAGES IS DIFFERENT THAN \$250,000, THEN INDICATE THE MODIFIED LIMIT: ----- \$ NA .00

43. COLLATERAL SOURCE INFORMATION:  
ENTER TO THE NEAREST PERCENT (use no decimals) THE PERCENT RECOVERY FOR ECONOMIC LOSS FROM: NA

A. <input type="checkbox"/> % Health	D. <input type="checkbox"/> % Automobile
B. <input type="checkbox"/> % Disability	E. <input type="checkbox"/> % Medicare, Medicaid & Social Security
C. <input type="checkbox"/> % Workers' Compensation	F. <input type="checkbox"/> % Other sources, specify: _____

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: NA

CONTACT PERSON: Kathleen Lamb ADDRESS: 1000 Wilson Blvd.  
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