

FLORIDA DEPARTMENT OF INSURANCE  
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING FORM FILE# 10180-0

PRIMARY CARRIER

Company Code 4 4 0 3 0 (Florida Certificate of Authority Number)

Company Name FLORIDA OSTEOPATHIC INSURANCE TRUST

Policy Number \_\_\_\_\_

EXCESS CARRIER

Company Code    (Florida Certificate of Authority Number)

Company Name \_\_\_\_\_

Policy Number \_\_\_\_\_

Calendar Year Claim Closed 83 FCC MM1 IAC 3

Insured Aurelio A. Ortiz, M.D.

Address 2108 Moore Drive, Dade City, Florida, 33525

County Code 28

(1) Speciality General/Family Practice Code 13

(2) Date of Incident (Month, Day, Year) 02 27 80

(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) 01 27 81

(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) 02 11 83

A. Primary Indemnity \$ \$20,677. C. Excess Indemnity \$ \_\_\_\_\_

B. Primary Defense \$ \$7091. 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)   

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

17Y0 Female tx by physician in Emergency Room and transferred to Shands Hospital, post-gunshot wound. Died during surgery on table.