

Previously Reported A83-6906-82

FLORIDA DEPARTMENT OF INSURANCE  
FLORIDA MEDICAL PROFESSIONAL LIABILITY  
INSURANCE CLAIMS REPORT

DEPARTMENT FILE NO. 80 1537  
INSURER'S CLAIM NO. A83-6906-82

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: Rotsden Jack  
(last name, first name, middle name)  
STREET ADDRESS: 1236 Masan  
CITY, STATE: Dallas Tex ZIP: 32017 COUNTY CODE: 08  
(See Table B)
4. PRIMARY POLICY NUMBER: 12712 EXCESS POLICY NUMBER: \_\_\_\_\_  
PRIMARY POLICY LIMITS: \$ 500,000 .00 (per claim) EXCESS POLICY LIMITS: \$ \_\_\_\_\_ .00 (per claim)  
\$ \_\_\_\_\_ .00 (per aggregate) \$ \_\_\_\_\_ .00 (per aggregate)
5. Is the insured physician a Foreign Medical Graduate? If yes, enter the country in which primary medical education was received: \_\_\_\_\_  
 (1) Yes  (2) No
6. PROFESSION OR BUSINESS: (check one)  
 (1) Physicians & Surgeons  (4) Other Medical Professionals  (7) Other Health Care Facilities  
 (2) Hospitals  (5) Clinics  
 (3) Podiatrists  (6) Ambulatory Surgical Centers
7. SPECIALTY CODE: 8.0.24.9 (Applies to physicians, surgeons, and other health care professionals. Use ISO Common Statistical Base Classification Codes.)  
(See Table C)
8. BOARD CERTIFICATION: (check one)  
 (1) In specialty coded in Item 7, above.  
 (2) In a different specialty.  
 (3) In both the specialty in Item 7 and another specialty. Enter the additional specialty code here: \_\_\_\_\_  
 (4) Insured is not board certified.
9. PLACE WHERE INJURY OCCURRED: (check one)  
 (1) Hospital Inpatient Facility  (4) Nursing Home  (7) Other Outpatient Facility  
 (2) Emergency Room  (5) Physician's Office  (8) Other Location  
 (3) Hospital Outpatient Facility  (6) Patient's Home  (9) 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: Hadifax Hosp INSTITUTION CODE: 100017  
(See Table D)
12. LOCATION OF INSTITUTIONAL INJURY: (check one)  
 (1) Patient's Room  (4) Labor & Delivery Room  (7) Critical Care Unit  
 (2) Operating Suite  (5) Physical Therapy Dept.  (8) Special Procedure Room  
 (3) Recovery Room  (6) Nursery  (9) Radiology
13. DATE OF OCCURRENCE: 11/30/82  
DATE REPORTED TO INSURER: 12/4/82
14. INJURED PERSON'S AGE: 46 INJURED PERSON'S SEX: M  (circle one)

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BUREAU OF RATES  
(See Table C)

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 INSURER'S CLAIM NO. AG06

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: <u>electrolyte imbalance</u>	(LEAVE BLANK) 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>dent in A coma</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>Base Dr'd electrolyte imbalance</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>coma</u>	19.

20. SEVERITY OF INJURY: (check only one -- rate most serious injury if several are involved.)

- (1) Emotional only - - - Fright, no physical damage.
- (2) Insignificant - - - Lacerations, contusions, minor scars, rash. No delay.
- Temp-  (3) Minor - - - - - Infections, misset fracture, fall in hospital. Recovery delayed.
- orary  (4) Major - - - - - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
- (5) Minor - - - - - Loss of fingers, loss or damage to organs. Includes nondisabling injuries.
- Perma-  (6) Significant - - - - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
- nent  (7) Major - - - - - Paraplegia, blindness, loss of two limbs, brain damage.
- (8) Grave - - - - - Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
- (9) Death

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21. DATE OF SUIT, IF ANY: 11/30/84

22. LIST OTHER DEFENDANTS INVOLVED IN THIS CLAIM, THE INSURER'S CODE NUMBER AND THE COMPANION CLAIM FILE IDENTIFICATION NUMBER:

	<u>DEFENDANT'S NAME (last name, first name)</u>	<u>INSURER CODE NO.</u>	<u>INSURER FILE ID.</u>
1)	<u>Holmes Hsp</u>	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

23. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (check one)  
 (1) Yes  (2) No

24. DATE OF FINAL CLAIM DISPOSITION: 9/9/84

25. FINAL METHOD OF CLAIM DISPOSITION:  
 (1) Settled by parties.  
 (2) Disposed of by a court.  
 (3) Disposed of by arbitration.

26. SETTLEMENT: (check one)  
 (1) Within the presuit period as set forth in Section 768.57, Florida Statute (usually within 90 days).  
 (2) After arbitration is initiated or prior to suit being filed.  
 (3) Within 90 days of suit being filed.  
 (4) More than 90 days after suit is filed and prior to or during the course of mandatory settlement conference.  
 (5) Prior to completion of the swearing of the jury.  
 (6) Prior to filing of the notice of appeal.  
 (7) After notice of appeal is filed or post-judgment relief or action is required for recovery.  
 (8) During appeal.  
 (9) After appeal.  
 (10) Claim or suit abandoned.

27. COURT: (check one)

<input type="checkbox"/> (1) No court proceedings.	<input type="checkbox"/> (6) Judgment for the plaintiff.
<input type="checkbox"/> (2) Directed verdict for plaintiff.	<input type="checkbox"/> (7) Judgment for the defendant.
<input type="checkbox"/> (3) Directed verdict for defendant.	<input type="checkbox"/> (8) Judgment for the plaintiff after appeal.
<input type="checkbox"/> (4) Judgment notwithstanding the verdict for the plaintiff.	<input type="checkbox"/> (9) Judgment for the defendant after appeal.
<input type="checkbox"/> (5) Judgment notwithstanding the verdict for the defendant.	<input checked="" type="checkbox"/> (10) Other.

28. ARBITRATION: (check one)

<input checked="" type="checkbox"/> (1) Claim not subject to arbitration.	<input type="checkbox"/> (3) Award for plaintiff.
<input type="checkbox"/> (2) Claim subject to arbitration, but previously coded disposition reached in lieu of award.	<input type="checkbox"/> (4) Award for defendant.

29. WAS THERE AN ITEMIZED VERDICT UNDER FLORIDA STATUTE 768.48? (check one)  
 (1) Yes  (2) No (If yes, please attach copy of settlement or verdict.)

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 INSURER'S CLAIM NO. A 6906

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: ----- \$ 9570 .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:

	<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: ----- \$ 0 .00
39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:
- A) PRESENT VALUE OF PERIODIC PAYMENTS ----- \$ 0 .00
- B) COST TO THE INSURER OF THE PAYMENTS ----- \$ 0 .00
- C) TOTAL EXPECTED PAYMENT TO PLAINTIFF ----- \$ 0 .00
- D) DID YOU PURCHASE AN ANNUITY?  (1) Yes  (2) No

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

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41. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: N/A

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CONTACT PERSON: Wm J. Thompson ADDRESS 1000 Riverside Avenue, P.O. Box 44033  
 TELEPHONE: (904) 354-5910 Jacksonville, Florida 32231-4033