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FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

0161

DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. 75-81

BUREAU OF RATES

South Broward Hospital District Physician's

1. PRIMARY INSURER NAME: Professional Liability Insurance Trust INSURER CODE: 4, 4, 0, 6
(See Table

2. EXCESS INSURER NAME: Florida Patient's Compensation Fund INSURER CODE: 4, 6, 0, 1
(See Table

3. INSURED'S NAME: Shawbitz, Michael, M.D.
(Last Name, First and Middle Name)

1005 Mar-Walt Drive

STREET ADDRESS:

CITY, STATE: FT. Walton Beach, FL ZIP: 32540

COUNTY CODE: UNK
(See Table B)

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	417	\$ 100,000 .00	\$ NA .00
EXCESS INSURER :	9268	\$ UNK	\$ UNK

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
 (02) Hospitals
 (03) Podiatrists
 (04) Other Medical Professionals
 (05) Clinics
 (06) Ambulatory Surgical Centers
 (07) Other Health Care Facilities

7. SPECIALTY CODE: 9, 0, 2, 5, 7 (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
 (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 (8) Other, then provide a description of the place where the injury occurred: _____

11. NAME OF INSTITUTION: Memorial Hospital Hollywood INSTITUTION CODE: 1, 0, 0, 0
(See Table

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

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DATE OF OCCURRENCE: 10 / 20 / 81

DATE REPORTED TO INSURER: 03 / 11 / 82

INJURED PERSON'S AGE: 75 Years (If less than one year, then enter 01)

INJURED PERSON'S SEX: M F (Circle one)

INJURED PERSON'S NAME: _____
 Last Name First and Middle Initial

FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: <u>Stroke</u>	(LEAVE BLANK) 15.
DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: <u>NA</u>	16.
DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: <u>Alleged improper treatment</u>	17.
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>NA</u>	18.
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>Paralysis - loss of speech</u>	19.

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-X (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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1. DATE OF SUIT, IF ANY: 09 / 09 / 83

2. LIST OTHER DEFENDANTS INVOLVED IN THIS CLAIM, THE INSURER'S NUMBER AND THE COMPANION CLAIM FILE ID NUMBER:

DEFENDANT'S NAME (Last Name, First Name)	INSURER CODE NO.	INSURER FILE ID.
1) Adams, Charles, M.D.	44060	75-81
2) Rosenthal & Adams, M.D., P.A.	44060	75-81
3)		
4)		
5)		

3. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (Check one)

(01) Yes (02) No

4. DATE OF FINAL CLAIM DISPOSITION: 09 / 23 / 86

5. FINAL METHOD OF CLAIM DISPOSITION:

(01) Settled by parties.
 (02) Disposed of by a court.
 (03) Disposed of by arbitration.

6. SETTLEMENT: (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 is filed and prior to or during the course of mandatory settlement conference.
 (05) Prior to completion of the swearing of the jury.
 (06) Prior to filing of the 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.

7. COURT: (Check one)

(01) No court proceedings. (06) Judgment for the plaintiff.
 (02) Directed verdict for plaintiff. (07) Judgment for the defendant.
 (03) Directed verdict for defendant. (08) Judgment for the plaintiff after appeal.
 (04) Judgment notwithstanding the verdict for the plaintiff. (09) Judgment for the defendant after appeal.
 (05) Judgment notwithstanding the verdict for the defendant. (10) Other.
 (11) Summary judgment for the plaintiff.
 (12) Summary judgment for the defendant.

8. ARBITRATION: (Check one)

(01) Claim not subject to arbitration. (03) Award for plaintiff.
 (02) Claim subject to arbitration, but previously coded (04) Award for defendant.
disposition reached in lieu of award.

9. WAS THERE AN ITEMIZED VERDICT UNDER FLORIDA STATUTE 768.48? (Check one)

(01) Yes (02) No (If yes, please attach copy of settlement or verdict.)

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30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - - - - - \$ -0-
31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: - - - - - \$ -0-
32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: - - - - - \$ -0-
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - - - - - \$ -0-
34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: - - - - - NA
35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: - - - - - NA
36. INJURED PERSON'S GROSS WEEKLY INCOME: - - - - - \$ NA

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

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

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: - - - - - \$ -0-

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:
- A) PRESENT VALUE OF PERIODIC PAYMENTS - - - - - \$ _____
- B) COST TO THE INSURER OF THE PAYMENTS - - - - - \$ _____
- C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - - - - - \$ _____
- D) DID YOU PURCHASE AN ANNUITY? (01) Yes X (02) No

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

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

CONTACT PERSON: Bea Antonoff ADDRESS 921 N. 35 Avenue
 TELEPHONE: (305) 987-1455 Hollywood, Florida 33021