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FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

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DEPARTMENT FILE NO. _____
INSURER'S CLAIM NO. 86-8178-006

BUREAU OF RATES

1. PRIMARY INSURER NAME: Physicians Protective Trust Fund INSURER CODE: 44050
(See Table A)
2. EXCESS INSURER NAME: NIA INSURER CODE: NIA
(See Table A)
3. INSURED'S NAME: Punyani Sat P.
(Last Name, First and Middle Name)
STREET ADDRESS: Hollywood Memorial Hospital
3501 Johnson Street
CITY, STATE: Cooper City, Florida ZIP: 33021 COUNTY CODE: 110
(See Table B)

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>0218900</u>	<u>\$ 1,000,000.00</u>	<u>\$ 3,000,000.00</u>
EXCESS INSURER :	<u>NIA</u>	<u>\$ NIA</u>	<u>\$ NIA</u>

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 unk unk

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: 810272 (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: NIA

11. NAME OF INSTITUTION: Memorial Hospital, Hollywood INSTITUTION CODE: 1101038
(See Table D)

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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3. DATE OF OCCURRENCE: 03/12/84
 DATE REPORTED TO INSURER: 07/18/86
 4. INJURED PERSON'S AGE: 26 Years (If less than one year, then enter 01)
 INJURED PERSON'S SEX: M F (Circle one)

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

5. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED:	(LEAVE BLANK)
<u>lacerations of left ear, forearm and right shoulder and dizziness following an automobile accident.</u>	15.
6. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:	16.
<u>N/A</u>	
7. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:	17.
<u>Patient had to have additional surgery to remove several glass fragments from the area behind left ear</u>	
8. 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:	18.
<u>Doctor Punyani saw patient in ER, evaluated him and called in a plastic surgeon who repaired and sutured patient's lacerations.</u>	
9. 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:	19.
<u>Patient alleges that the failure to remove glass fragments timely caused him to have scarring and loss of hearing</u>	

0. 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- (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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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: - - - - - \$ 0.00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - - - - - \$ 375.00
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 - - - - - \$ 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? (01) Yes (02) No

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

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

CONTACT PERSON: ama Jones ADDRESS 6360 N.W Fifth Way
 TELEPHONE: (205) 491-5607 Fort Lauderdale Florida 33309