

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

8901184

DEPT. FILE NO.

BUREAU OF RATES

INSURER'S CLAIM NUMBER: 509JN434209C001

1. PRIMARY INSURER NAME: ST. PAUL INSURER CODE: 01470  
(See Table A)

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

3a. HEALTH CARE PROVIDER: NEWMAN, ROBERT ELLIOTT  
(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: 0027596

3c. INSURED'S NAME: NEWMAN, ROBERT E.

STREET ADDRESS: 3660 - 2 CENTRAL AVE.

CITY: FT. MYERS STATE: FL ZIP: 33901 COUNTY CODE: 04  
(See Table B)

	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>509JN4342</u>	<u>\$1,000,000.00</u>	<u>\$1,000,000.00</u>
EXCESS INSURER:	_____	\$ _____ .00	\$ _____ .00

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 \_\_\_ (04) Dentist \_\_\_ (07) Crisis Stabilization Unit  
\_\_\_ (02) Hospitals \_\_\_ (05) Abortion Clinics \_\_\_ (08) Health Maintenance  
\_\_\_ (03) Podiatrists \_\_\_ (06) Ambulatory Surgical Centers Organization

7. SPECIALTY CODE: 80249 (Applies to physicians, surgeons, and dentists.)  
(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. 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 \_\_\_ (04) Nursing Home \_\_\_ (07) Other Outpatient Facility  
\_\_\_ (02) Emergency Room \_\_\_ (05) Physician's Office \_\_\_ (08) Other Location  
\_\_\_ (03) Hospital Outpatient Facility \_\_\_ (06) Patient's Home \_\_\_ (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: \_\_\_\_\_

AMI

11. NAME OF INSTITUTION: ANCLOTE MANOR Hospital INSTITUTION CODE: 104003

(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
- (11) Other Psychiatric care

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13. DATE OF OCCURRENCE: 7/24/85

DATE REPORTED TO INSURER: 4/17/88

14. INJURED PERSON'S AGE: 43 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: delusional, assaultive + psychotic Schizophrenia (LEAVE BLANK) 15.

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

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: Psychiatric 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: 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: INCARCERATED AT MENTAL FACILITY 19.

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20. 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

21. DATE OF SUIT, IF ANY: NONE

21.1 CIRCUIT COURT CASE NUMBER: N/A

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: N/A (SEE TABLE B)

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

	<u>DEFENDANT'S NAME (Last Name, First Name)</u>	<u>INSURER CODE NO.</u>	<u>INSURER FILE ID.</u>
1)	<u>N/A</u>		
2)			
3)			
4)			
5)			

23. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (Check one)  
 (01) Yes  (02) No

24. DATE OF FINAL CLAIM DISPOSITION: 3/10/89

25. FINAL METHOD OF CLAIM DISPOSITION:  
 (01) Settled by parties.  
 (02) Disposed of by a court.  
 (03) Disposed of by arbitration.

26. STAGE OF THE LEGAL SYSTEM AT WHICH SETTLEMENT WAS REACHED OR AWARD MADE: (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 filed and prior to or during the course of mandatory settlement conference
- (05) During trial but before court verdict.
- (06) After court verdict and prior to filing of notice of appeal.
- (07) After notice of appeal is filed or post-judgement relief or action is required for recovery.
- (08) During appeal.
- (09) After appeal.
- (10) Claim or suit abandoned.

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

28. ARBITRATION: (Check one)
- |  |  |
|--|--|
| <input checked="" type="checkbox"/> (01) Claim not subject to arbitration.                           | <input type="checkbox"/> (03) Award for plaintiff. |
| <input type="checkbox"/> (02) Claim subject to arbitration, but settlement reached in lieu of award. | <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: ----- \$ 0 .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: ----- \$ 0 .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- Medical expnts. \$ 15,655 .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</u> .00	\$ <u>0</u> .00	\$ <u>0</u> .00
B) ESTIMATED FUTURE - - - -	\$ <u>0</u> .00	\$ <u>0</u> .00	\$ <u>0</u> .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  | \$ <u>0</u> .00 |
| B) COST TO THE INSURER OF THE PAYMENTS | \$ <u>0</u> .00 |
| C) TOTAL EXPECTED PAYMENT TO PLAINTIFF | \$ <u>0</u> .00 |
- 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

- (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: - - - - - \$ \_\_\_\_\_ .00

43. COLLATERAL SOURCE INFORMATION:

ENTER TO THE NEAREST PERCENT (use no decimals) THE PERCENT RECOVERY FOR ECONOMIC LOSS FROM:

- |                               |  |
|-------------------------------|--|
| A. ___% Health                | D. ___% Automobile   |
| B. ___% Disability            | E. ___% Medicare, Medicaid & Social Security               |
| C. ___% Workers' Compensation | F. <u>100</u> % Other sources, specify: <u>His Father.</u> |

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

ST. PAUL FIRE & MARINE INS. CO.  
TAMPA, FLORIDA

CONTACT PERSON: \_\_\_\_\_ ADDRESS: P. O. Box 31826  
TELEPHONE: (813) 286-1154 Tampa, Florida 33631-3826  
APR 07 1989

RICHARD L. FAGLEY  
SR. CLAIM REPRESENTATIVE