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CASUALTY FORMS & RATES

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

9802217
DEPT. FILE NO.

INSURER'S CLAIM NUMBER: CNA-0301-96

1. PRIMARY INSURER NAME: TRANSATLANTIC REINSURANCE Co. INSURER CODE: 0,9,4,8,3 (See Table A)

2. EXCESS INSURER NAME: NA INSURER CODE: N,A (See Table A)

3a. HEALTH CARE PROVIDER: MARTIN, JOHN Gerard
(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: 0,0,4,7,1,8,7

3c. INSURED'S NAME: EMSA/INPHYNET MEDICAL MANAGEMENT

STREET ADDRESS: 1200 S. PINE ISLAND RD; Suite 600

CITY: Ft. LAUDERDALE STATE: FL ZIP: 3,3,3,2,4 COUNTY CODE: 1,0 (See Table B)

4.

| | POLICY NUMBER | PER CLAIM POLICY LIMITS | AGGREGATE POLICY LIMITS |
|---|---|---|---|
| PRIMARY INSURER: | MSP1023806384 | $1,000,000 .00 | $3,000,000 .00 |
| EXCESS INSURER: | N/A | $ N/A .00 | $ N/A .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: N/A

6. PROFESSION OR BUSINESS: (Check one)
- ✓ (01) Physicians & Surgeons
- ___ (02) Hospitals
- ___ (03) Podiatrists
- ___ (04) Dentist
- ___ (05) Abortion Clinics
- ___ (06) Ambulatory Surgical Centers
- ___ (07) Crisis Stabilization Un
- ___ (08) Health Maintenance Organization

7. SPECIALTY CODE: 0,0,1,0,2 (See Table C) (Applies to physicians, surgeons, and dentists. Use ISO Common Statistical Base Classification Codes.)

8. BOARD CERTIFICATION: (Check one)
- X (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
- ___ (02) Emergency Room
- ___ (03) Hospital Outpatient Facility
- ___ (04) Nursing Home
- ___ (05) Physician's Office
- ___ (06) Patient's Home
- ___ (07) Other Outpatient Facility
- X (08) Other Location
- ___ (09) Other Hospital/Institutio

10. IF PLACE OF INJURY (above) IS CHECKED AS ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJUR OCCURRED: NORTH BROWARD DETENTION CENTER

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11. NAME OF INSTITUTION: NORTH BROWARD DETENTION CENTER INSTITUTION CODE: NA
(See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)

| | | |
|---|---|---|
| ___ (01) Patient's Room | ___ (05) Physical Therapy Dept. | ___ (09) Radiology |
| ___ (02) Operating Suite | ___ (06) Nursery | ___ (10) Emergency Room |
| ___ (03) Recovery Room | ___ (07) Critical Care Unit | ✓ (11) Other JAIL |
| ___ (04) Labor & Delivery Room | ___ (08) Special Procedure Room | |

13. DATE OF OCCURRENCE: 8/21/96

DATE REPORTED TO INSURER: 9/3/96

14. INJURED PERSON'S AGE: 22 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: _____
ial

STREET ADDRESS:

CITY: _____

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: (LEAVE BLANK)
HEMORRHAGIC AND NECROTIZING BRONCHOPNEUMONIA WITH SEPSIS
POSSIBLE EXCESSIVE DOSE OR ADVERSE REACTION TO THORAZINE
RESULTING IN DEATH. 15. _____

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:
NO MISDIAGNOSIS 16. _____

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:
SEE #15 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:
SEE #15 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:
SEE #15 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 delaye

___(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.

X (09) Death

21. DATE OF SUIT, IF ANY: 10/3/97

21.1 CIRCUIT COURT CASE NUMBER: 97-7220-CIV FERGUSON

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 10 (SEE TABLE B)

22. 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) | JOHN CATANO, P.A. | UNKNOWN | UNKNOWN |
| 2) | SANDRA ARANSERIA, LPN | UNKNOWN | UNKNOWN |
| 3) | MARIE MERZIUS, LPN | UNKNOWN | UNKNOWN |
| 4) | JOE BRYANT, RN | UNKNOWN | UNKNOWN |
| 5) | JOAN BAUERSMITH, RN | UNKNOWN | UNKNOWN |

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

24. DATE OF FINAL CLAIM DISPOSITION: 10/16/98

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 conferen
___(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.

27. COURT: (Check one)

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

28. ARBITRATION: (Check one)

X (01) Claim not subject to arbitration.
___(02) Claim subject to arbitration, but settlement reached in lieu of award.
___(03) Award for plaintiff.
___(04) Award for defendant.

29. Was there an itemized verdict? (Check one)

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

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - - - - - - - - - - - - - - - - - - - - $ 305,000 .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: - - - - - - - - - - - - - - - - - - - - - $ 28,490 .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - - - - - - - - - - - - - - - - - - - - - - - - - - $ 3186 .00

34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: - - - - - - - - - - - - - - - - UNK days

35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: - - - - - - - - - - - - - - UNK days

36. INJURED PERSON'S GROSS WEEKLY INCOME: - - - - - - - - - - - - - - - - - - - - - - - - - - - $ UNK .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

| | MEDICAL | WAGE LOSS | OTHER EXPENSES |
|---|---|---|---|
| A) INCURRED TO DATE | $ UNK .00 | $ UNK .00 | $ UNK .00 |
| B) ESTIMATED FUTURE | $ UNK .00 | $ UNK .00 | $ UNK .00 |

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: - - - - - - - - - - - - - - - - - - - - $ 305,000 .00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:

A) PRESENT VALUE OF PERIODIC PAYMENTS - - - - - - - - - - - - - - - - - - - - - - - - - - $ NA .00

B) COST TO THE INSURER OF THE PAYMENTS - - - - - - - - - - - - - - - - - - - - - - - - - - $ NA .00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF - - - - - - - - - - - - - - - - - - - - - - - - - - $ NA .00

D) DID YOU PURCHASE AN ANNUITY? ___ (01) Yes X (02) No

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

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

X (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: - - - - - - - - - - - - - - - - - - - - - - $ N/A .00

43. COLLATERAL SOURCE INFORMATION:
ENTER TO THE NEAREST PERCENT (use no decimals) THE PERCENT RECOVERY FOR ECONOMIC LOSS FROM:

A. ____% Health
B. ____% Disability
C. ____% Workers' Compensation
D. ____% Automobile
E. ____% Medicare, Medicaid & Social Security
F. ____% Other sources, specify: N A

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

CONTACT PERSON: NANCY THOMAS ADDRESS 820 GESSNER Suite 1000
TELEPHONE: (713) 935-8868 HOUSTON, TX 77024