LIBRARY OF
California Medical Malpractice Forms

MITCHELL LAW GROUP
JEFFREY S. MITCHELL, ESQ.
REBECCA BYRNE, ESQ., AND
MIKA BROWN, PARALEGAL EDITORS

THE RECORDER
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Meet the Authors</td>
<td>4</td>
</tr>
<tr>
<td>New Case Checklist (Procedural)</td>
<td>5-6</td>
</tr>
<tr>
<td>Letter to Defendant’s Attorney/Insurance Representative Advising of Representation</td>
<td>7-8</td>
</tr>
<tr>
<td>Complaint - Elder Abuse</td>
<td>9-29</td>
</tr>
<tr>
<td>Plaintiff’s Proposed Jury Instructions</td>
<td>30-31</td>
</tr>
<tr>
<td>Settled Case Checklist</td>
<td>32</td>
</tr>
<tr>
<td>Other Exemplars</td>
<td>33</td>
</tr>
</tbody>
</table>
INTRODUCTION

Library of California Medical Malpractice Law Forms addresses issues as they commonly arise through the litigation process—from considering the elements of a malpractice cause of action, through investigating and preparing a case, to managing trial issues.
MEET THE AUTHORS

JEFF MITCHELL
In his very busy career, Mitchell has already attained two record setting verdicts, secured innumerable six, seven and eight figure settlements and helped shaped the future of the law as it pertains to medical malpractice in California. He is a frequently sought-after speaker on issues pertaining to jury selection, cross examination, argument, expert witness utilization and psychology of trial practice in California and throughout the country. He is annually listed as a Northern California Super Lawyer, one of San Francisco’s Top Attorneys, one of California’s Top 100 trial lawyers and is rated annually by his peers as one of the Best Lawyers in America. Jeff was also honored as San Francisco’s Trial Lawyer of the Year which is annually given by the San Francisco Trial Lawyer’s Association.

REBECCA L. BYRNE
Byrne has specialized in medical malpractice cases since 1991. However, unlike most attorneys specializing in this area of law, she has represented plaintiffs and defended defendants in such cases. Her experience working in firms which represent patients and/or patients’ families has been enriched and enhanced by her experience working in firms which defend medical care providers in medical negligence cases.

MIKA BROWN
Brown is responsible for various case management tasks. She assists attorneys Jeffrey Mitchell and Rebecca Byrne by preparing legal documents, drafting legal discovery, scheduling depositions and communicating with clients and defense counsel. Mika also partakes in drafting mediation briefs and motions. She is grateful to work in a small boutique law firm, which has allowed her to undertake a great role in the firm’s activities.

Mika is a San Francisco native who received her Bachelor of Arts Degree in Legal Studies from the University of California, Santa Cruz. She spent her senior year in college studying abroad in Tokyo focusing on international relations and global government and she is also fluent in Japanese. In her free time, Mika enjoys being outdoors, camping, swimming, traveling and exploring San Francisco. Mika is currently a law student at Santa Clara University School of Law. Upon graduation from law school, Mika plans to continue working in the legal field of civil litigation, possibility focusing in the specialized, but complex area of medical malpractice law.
### New Case Checklist (Procedural)

**Checklist**
Medical Malpractice Plaintiff’s Attorney

<table>
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<tr>
<th>Done?</th>
<th>To-Do:</th>
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<tbody>
<tr>
<td></td>
<td>Have Client sign Fee-Agreement</td>
</tr>
<tr>
<td></td>
<td>Receive all medical records in client’s possession</td>
</tr>
<tr>
<td></td>
<td>Have client sign HIPAA medical authorization</td>
</tr>
<tr>
<td></td>
<td>- Use to investigate claims and theories of liability</td>
</tr>
<tr>
<td></td>
<td>- Form must comply with Civ. Code, § 56.11</td>
</tr>
<tr>
<td></td>
<td>Determine whether public entity will be defendant</td>
</tr>
<tr>
<td></td>
<td>- Comply with notice requirements of Government Claims Act [Gov. Code, §§ 945.4, 911.2]</td>
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<tr>
<td></td>
<td>- Commence action within six-month statute of limitations [Gov. Code, § 945.6, subd. (a)(1)]</td>
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<tr>
<td></td>
<td>Determine theories of liability</td>
</tr>
<tr>
<td></td>
<td>- If action for professional negligence against health care provider to which MICRA provisions apply</td>
</tr>
<tr>
<td></td>
<td>Advise client as to MICRA’s limitations on contingency fees [Bus. &amp; Prof. Code, § 6146] and on damages [Civ. Code, §§ 3333.1, 3333.2; Civ. Proc. Code, § 667.7]</td>
</tr>
<tr>
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<td>Serve notice of intent to bring action on potential defendant or claims representative [Civ. Proc. Code, § 364]</td>
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<tr>
<td></td>
<td>Commence action within the applicable statutes of limitations [Civ. Proc. Code, § 340.5]</td>
</tr>
<tr>
<td></td>
<td>Obtain an expert witnesses to testify as to standard of care and causation</td>
</tr>
<tr>
<td></td>
<td>Inform Client of applicable provisions:</td>
</tr>
<tr>
<td></td>
<td>- If action for other than professional negligence to which MICRA provisions do not apply:</td>
</tr>
<tr>
<td></td>
<td>o Advise client as to absence of limitation on contingency fees and damages</td>
</tr>
<tr>
<td></td>
<td>- If hybrid action involving MICRA and non-MICRA claims:</td>
</tr>
<tr>
<td></td>
<td>o Advise client that if client obtains recovery that may be based on non-MICRA theory, limitation on contingency fees [Bus. &amp; Prof. Code, § 6146] will not apply</td>
</tr>
<tr>
<td>Before serving Complaint, consider demand for settlement or offer to compromise [Code Civ. Proc., § 998]</td>
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<td></td>
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<tr>
<td>File Complaint with applicable Superior Court</td>
<td></td>
</tr>
<tr>
<td>Serve filed court documents on applicable defendants</td>
<td></td>
</tr>
<tr>
<td>File Proof of Service of Summons with the Court</td>
<td></td>
</tr>
<tr>
<td>Commence Discovery</td>
<td></td>
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<tr>
<td>Schedule Depositions of Defendants, Percipient Witnesses, etc.</td>
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</tbody>
</table>
[DATE]

Via Certified Mail RRR

[CONTACT NAME]
[TITLE], [INSURANCE COMPANY] Board of Directors

[HEALTH CARE PROVIDER]

[ADDRESS]

[CITY], CA [ZIP CODE]

Re: [PLAINTIFF NAME] Matter

Dear [CONTACT NAME]:

The [LAW FIRM NAME] has undertaken the representation of [PLAINTIFF NAME], the surviving wife of [DECEDEDENT NAME], who passed away at [HEALTH CARE PROVIDER] on [DATE]. The facts of this matter are well known to you and I won’t recount them here. Suffice it to say that [DECEDEDENT NAME] passed away prematurely at [HEALTH CARE PROVIDER] and the causes related to his death are directly attributable to professional negligence at [HEALTH CARE PROVIDER].

As you know, [HEALTH CARE PROVIDER] graciously undertook what sounds to be a very thorough investigation and arrived at the conclusion that errors were made and that those errors contributed to or were the outright causes of [DECEDEDENT NAME]’s death. [HEALTH CARE PROVIDER] then, to its great credit, agreed to meet with [PLAINTIFF NAME] and her daughter and explained the investigation process and then conclusions and findings of [HEALTH CARE PROVIDER]’s own peer review analysis. The [PLAINTIFF]s were very appreciative of the efforts made by [HEALTH CARE PROVIDER] and the candor.

Sadly the revelations were bittersweet as they confirmed what [PLAINTIFF NAME] believed to be true. Her husband’s death was premature and most certainly preventable.
[PLAINTIFF NAME] has asked our firm to request that [HEALTH CARE PROVIDER] stand behind its own admissions of fault and agree to compensate [PLAINTIFF NAME] for her loss.

While the [LAW FIRM NAME] believes that [PLAINTIFF NAME]’s entitlement to compensation significantly exceeds the statutory maximum for general damages of $250,000. [PLAINTIFF NAME] has authorized our firm to extend a demand for $250,000 to fully satisfy her claims against [HEALTH CARE PROVIDER]. Please don’t view this as a starting point for any negotiations, it’s the demand and will not be reduced for any reason.

Some cases need to be litigated but in this setting we don’t view this as one of those. [HEALTH CARE PROVIDER] understands the issues, has done a complete root cause analysis and now just needs to stand behind their findings and fairly compensate [PLAINTIFF NAME] in the only way we currently have of making things right.

As I mentioned, we would much prefer to resolve this matter without having to go through the unnecessary time and expense associated with formal litigation. The [PLAINTIFF]s have already experienced more heartache than they should have and a protracted litigation will only serve to perpetuate this grief.

I am enclosing a formal “Notice of Intent” document along with this letter but hope that we won’t need to actually file and serve a summons and complaint.

The one year wrongful death statute of limitations is fast approaching and we would be willing to agree to a tolling of the statute to allow [HEALTH CARE PROVIDER] some additional time to respond to our settlement offer.

Please share this letter with all the participants who attend the meeting with the [PLAINTIFF]s and then have one of them or a representative from [HEALTH CARE PROVIDER]’s errors and omissions carrier contact me.

Sincerely,

[ATTORNEY NAME],
Litigation Analyst
[LAW FIRM NAME]

Enc: Notice of Intent to Commence Litigation
COMPLAINT FOR DAMAGES FOR:

(1) Negligence

(2) Elder Abuse Under California Welfare & Institutions Code §15600 Et Seq.

COMES NOW Plaintiff, [PLAINTIFF NAME] ("Plaintiff"), to complain of Defendants, [DEFENDANT NAMES] and DOES 1 through 100, Inclusive, (“Defendants”) as follows:

GENERAL ALLEGATIONS

1. Plaintiff, [PLAINTIFF NAME], due to her infirmity, and for the purposes of this action only, is hereby declared an Incompetent Adult who will prosecute this action by and through her Guardian ad Litem, [GUARDIAN AD LITEM], who has been appointed Guardian ad Litem by order of this court.
2. At all times herein mentioned, Plaintiff, [PLAINTIFF NAME], was and is an adult over the age of 65.

3. At all times herein mentioned, Plaintiff, [PLAINTIFF NAME], was an “elder adult” as that term is defined in the Welfare & Institutions Code §15610.27.

4. At all times herein mentioned, Plaintiff, [PLAINTIFF NAME], resided in the County of [COUNTY], State of California.

5. At all times herein mentioned, Defendants, [DEFENDANT NAME], M.D. and [DEFENDANT NAME], M.D. and DOES 1 through 100, inclusive, were and are now physicians duly licensed to practice their profession, or were engaged in the practice of their profession, in the County of [COUNTY], State of California.

6. At all times herein mentioned, Defendants, [DEFENDANT NAMES] and DOES 1 through 100, inclusive, were and are: (a) engaged in owning, operating, maintaining, managing and doing business in the State of California; (b) engaged in rendering medical, surgical, clinical, diagnostic, nursing, skilled nursing, rehabilitation, and other custodial care and services to the general public for compensation; and (c) a corporation, partnership, sole proprietorship, joint venture, unincorporated association, or some other business entity doing business in the County [COUNTY], State of California, and duly organized and existing under and by virtue of the laws of the County of [COUNTY] and the State of California.

7. At all times herein mentioned, Defendants, [DEFENDANT NAMES] and DOES 1 through 100, inclusive, were and are in the business of providing long-term custodial care as a 24-hour facility and are subject to the requirements of federal and state law, and were at all times mentioned doing business in the City of [CITY], County of [COUNTY], in the State of California.

8. Plaintiff is informed and believes that Defendants, [DEFENDANT NAMES] and DOES 1 through 100, inclusive, are the owners, operators, and managers of [DEFENDANT NAME], and participated in, authorized, and/or directed the conduct of [DEFENDANT NAME] and its respective agents and employees at [DEFENDANT NAME] and are therefore liable for the acts and omissions of [DEFENDANT NAME], its agents and employees, as is more fully
9. Plaintiff is informed and believes that Defendants, [DEFENDANT NAMES] and DOES 1 through 100, inclusive, are the owners, operators, and managers of [DEFENDANT NAME], and participated in, authorized, and/or directed the conduct of [DEFENDANT NAME] and its respective agents and employees at [DEFENDANT NAME] and are therefore liable for the acts and omissions of [DEFENDANT NAME], its agents and employees, as is more fully herein alleged.

10. Since the true names and capacities, whether individual, corporate, associate, or otherwise, of the Defendants designated and sued as DOES 1-100, inclusive, are unknown to Plaintiff, those Defendants are designated by their fictitious names. Plaintiff alleges on information and belief that each of the Defendants designated and sued as a DOE is legally responsible in some manner for the events and happenings referred to herein below, and legally caused the injury and damages to Plaintiff as herein alleged. Plaintiff will ask leave of this Court to amend this pleading to insert the true names and capacities of these Defendants designed by their fictitious names when those facts become known to Plaintiff.

11. At all times herein mentioned, the Defendants DOES 1-50, inclusive, were and now are physicians, surgeons, nurses, medical personnel or other health care professionals, duly licensed to practice their profession, or engaged in the practice of their profession, in the Counties of [COUNTIES], State of California.

12. At all times mentioned herein, Defendants DOES 51-60, inclusive, were technicians, and laboratories or radiological facilities engaged in, and licensed to operate a business maintaining and offering laboratory facilities to the public and to the physicians and hospitals herein and others involved in the rendition of ancillary services and facilities incidental to the operation of a hospital, clinic or doctor's office and/or the provision of health services to the general public, and, in particular, to the Plaintiff herein.

13. At all times mentioned herein, Defendants DOES 61-70, inclusive, and each and every DOE in between, were and now are corporations, partnerships, sole proprietorships, joint ventures, unincorporated associations or some other business entities doing business in the State
of California and duly organized and existing under, and by virtue of the laws of the State of
California, each of which in some way contracted to provide, and/or in some other manner
provided, medical care and treatment or ancillary services to the general public, including the
Plaintiff herein.

14. At all times mentioned herein, Defendants DOES 71-80, inclusive, were
administrative and clerical staff engaged to operate the business of offering non-medical services
to the general public, including the Plaintiff herein.

15. At all times mentioned herein, Defendants DOES 81-90, inclusive, were Risk-
Bearing Organizations (“RBOs”) / Medical Business Organizations ("MBOs"), including but not
limited to HMOs, administering or managing the provision of health services, or agents thereof,
or middlepersons interfacing between an MBO and the health care providers actually providing
care to patients, including the Plaintiff herein.

16. During said periods of time hereinabove alleged, Defendants, and DOES 1-100,
inclusive, and each of them, agreed to perform and undertook to perform for the Plaintiff herein
all services necessary to the Plaintiff’s care, including both medical and non-medical services,
which included, but were not limited to, observation, attention, examination, evaluation,
diagnosis, care and treatment of the Plaintiff herein, as well as proper administrative and clerical
management of his health care and custodial care needs. In so doing, the Defendants, and each
of them, established a relationship with the Plaintiff herein, giving rise to each Defendant’s duty
to provide skillful management of the Plaintiff’s health conditions and medical, custodial,
clerical and administrative needs.

17. At all relevant times, Defendants, and each of them were the agents, servants,
employees, joint venturers, ostensible agents and/or contractors of each of the remaining
Defendants, and were, at all times acting within the course and scope of such agency, service,
employment, contract, and/or joint venture. Plaintiff is informed and believes, and upon said
basis alleges that, at all times herein mentioned, each of the Defendants hired and employed
agents, servants, staff members, employees, and/or joint venturers. Each Defendant had also
given prior approval and subsequent ratification for the conduct, acts, and/or omissions of the
other Defendants, and each of them.

18. At all relevant times, Defendants, [DEFENDANT NAMES] and DOES 1 through 100, operated, managed, maintained, oversaw and controlled the activities of all co-Defendants and DOES 1-100, inclusive, and each of them, so that the conduct, acts, and omissions of each co-Defendant and DOES 1-100, inclusive, and each of them, were the conduct, acts and omissions of Defendants, [DEFENDANT NAMES] and DOES 1 through 100, and, at all relevant times, said co-defendants were then acting as the actual or ostensible agents of Defendants, [DEFENDANT NAMES] and DOES 1 through 100.

19. At all times herein mentioned, Defendants, and each of them, when acting as a principal, was negligent in the selection and hiring of each and every other Co-Defendant as an agent, servant or employee and, furthermore, expressly directed, consented to, approved, affirmed, and ratified each and every action taken by the co-Defendants.

DIRECT AND VICARIOUS LIABILITY

20. That Defendants, [DEFENDANT NAMES] and DOES 1 through 100, and each of them, operated in such a way as to make their individual identities indistinguishable, and are, therefore, the mere alter egos of one another.

21. That Defendants, [DEFENDANT NAMES] and DOES 1 through 100, and each of them, through their managers, directors, officers, and other agents, directly oversaw, managed, and/or controlled all aspects of the operation and management of [DEFENDANT NAME], including but not limited to, the budget, staffing, staff training, policy and procedures manuals, accounts payable, accounts receivable, facility development and leasing, general accounting, cash management, pricing, reimbursement, capitalization, and profit and loss margins.

22. That Defendants, [DEFENDANT NAMES] and DOES 1 through 100, and each of them, through their managers, directors, officers, and other agents create budgets, policies, and procedures which their employees were required to implement and follow.

23. That Defendants, [DEFENDANT NAMES] and DOES 1 through 100, and each of them, through their administrators, directors, and managing agents, ratified all conduct of employees of [DEFENDANT NAME] and DOES 1 through 100, alleged herein.
24. That the tortious acts and omissions of [DEFENDANT NAME] and DOES 1 through 100, as alleged herein, were done in concert with each other and pursuant to a common design and agreement to accomplish a particular result, namely maximizing profits from the operation of [DEFENDANT NAME] and DOES 1 through 100, by underfunding and understaffing the facility. Moreover, [DEFENDANT NAME] and DOES 1 through 100, and each of them, aided and abetted each other in accomplishing the acts and omissions alleged herein.

25. That at all relevant times, [DEFENDANT NAME] and DOES 1 through 100, and each of them, by their acts and omissions as alleged herein, operated pursuant to an agreement, with a common purpose and community of interest, with an equal right of control, and subject to participation in profits and losses, as further alleged herein, such that they operated a joint enterprise or joint venture, subjecting each of them to liability for the acts and omissions of each other.

26. That at all relevant times, [DEFENDANT NAME] and DOES 1 through 100, and each of them, intentionally understaffed the facility and in doing so regularly and consistently violated and failed to meet the California state minimum staffing standards. In so doing this act, Defendants, [DEFENDANT NAMES] and DOES 1 through 100, and each of them, knew that patients at the facility, such as [PLAINTIFF NAME], would not and could not get the treatment to which they were entitled and knew that these patients would suffer injury as a result.

THE DEFENDANTS' WRONGFUL CONDUCT

27. At all relevant times, Plaintiff, [PLAINTIFF NAME], was a patient at [DEFENDANT NAME] or a resident at [DEFENDANT NAME], and as such, each of these facilities had the care and custody of the Plaintiff.

28. Discovery is continuing and Plaintiff is not yet clear either on how the corporate structure at [DEFENDANT NAMES] and DOES 1 through 100, inclusive, worked, or the specific relationship between the owners and managers of the facilities and the facilities themselves.

29. That Defendants, [DEFENDANT NAMES] and DOES 1 through 100, and each
of them, provided management services to their respective facilities, which governed and controlled the care and custodial services provided to Plaintiff, and that by virtue of their management and control over the facilities, Defendants, [DEFENDANT NAMES] and DOES 1 through 100, and each of them, voluntarily and impliedly assumed responsibility for providing supervisory and custodial services for Plaintiff’s care while she was a resident at the respective facilities.

30. That Defendants, [DEFENDANT NAMES], M.D., supervising agents and employees of [DEFENDANT NAMES] and DOES 1 through 100, and each of them, were at all relevant times responsible for rendering, overseeing, supervising, and approving the medical, nursing, and physical and occupational therapy care received by Plaintiff at [DEFENDANT NAME] and [DEFENDANT NAME]. In that role, [DEFENDANT NAME], M.D. and the supervising agents and employees of [DEFENDANT NAME] and [DEFENDANT NAME] and DOES 1 through 100, and each of them, were responsible for recognizing, diagnosing, managing, and/or treating [PLAINTIFF NAMES]’s progressive extremity weakness in order to avoid it worsening so as to result in paralysis. These Defendants, and each of them, neglected [PLAINTIFF NAME] by failing to appreciate her worsening weakness, failing to properly treat it, failing to avoid harmful therapies that could exacerbate the injury, and failing to ensure that the staff at [DEFENDANT NAME] and [DEFENDANT NAME] were properly treating and/or managing it. [DEFENDANT NAME], M.D. and the supervising agents and employees of [DEFENDANT NAME] and [DEFENDANT NAME], and DOES 1 through 100, and each of them, knowingly and intentionally failed to render treatment to the Plaintiff and failed to ensure that others treated her properly.

31. That the DEFENDANTS, and each of them, owed a duty to Plaintiff, yet failed to operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted standards and principles that apply to those providing services in such a facility as required by Health & Safety Code §1250, et. seq. and 42 C.F.R. §483.75(b). By way of example, DEFENDANTS, and each of them, failed to operate [DEFENDANT NAME] and [DEFENDANT NAME] in compliance with many of the statutes
and regulations set forth below.

32. That the DEFENDANTS, and each of them, owed a duty to Plaintiff, yet failed to provide services by sufficient numbers of personnel on a 24-hour basis to provide care to Plaintiff in accordance with resident care plans as required by California Health & Safety Code §1250, et. seq., 42 C.F.R. §483.30(a), and 22 C.C.R. § 72501(e). By way of example, DEFENDANTS, and each of them, failed to provide the facilities with sufficient number of personnel to implement the care plans and perform complete assessments to prevent the failure to recognize the progressive extremity weakness that ultimately resulted in paralysis due to delayed treatment. DEFENDANTS and each of them knew that patients, including [PLAINTIFF NAME], would not and could not receive adequate assessment and care and would suffer injury as a result. Further, Defendants [DEFENDANT NAMES] and DOES 1 through 100, and each of them, based upon prior Department of Health Services deficiencies, knew that inadequate care and inadequate staffing would result in harm to their patients, including [PLAINTIFF NAME], yet knowingly and intentionally persisted in offering inadequate care to their patients by understaffing the facilities.

33. Defendant [DEFENDANT NAME] and DOES 1 through 100, and each of them, knew as a result of resident assessments submitted by [DEFENDANT NAME] to the federal and state government, that it exceeded the state average with regard to, among other things, residents whose need for help with daily activities increased and residents who lost control of their bowels or bladder were more depressed or anxious. In spite of this knowledge, Defendants and each of them acted recklessly and neglectfully by failing to properly staff the facility and to properly recognize and/or treat [PLAINTIFF NAME]’s worsening extremity weakness. As a result of this reckless and neglectful conduct, [PLAINTIFF NAME] suffered permanent paralysis.

34. That the DEFENDANTS and each of them, owed a duty to their residents, including Plaintiff, yet failed to provide services and activities and failed to operate, own, manage, control and/or administer the facilities in a manner that enable their residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being, including Plaintiff, in accordance with a written plan of care as required by 42 U.S.C. §§1396r(b)(2) and
1396r(d)(1)(A), 42 C.F.R. §483.25, and 22 C.C.R. §§72501(e) and 72515(b). By way of example, the services the DEFENDANTS, and each of them, failed to provide included, but were not limited to, proper patient assessments so as to recognize worsening weakness and proper charting and recordkeeping.

35. That the DEFENDANTS, and each of them, owed a duty to their residents, including Plaintiff, yet failed to provide a sufficient budget and sufficient staffing to meet the care needs of their residents, including Plaintiff, as required by 42 U.S.C. §1396r(b)(4)(C). By way of example, the services the DEFENDANTS, and each of them, failed to provide included, but were not limited to, the proper method to perform patient assessments and the proper method to do proper charting and recordkeeping.

36. That the DEFENDANTS, and each of them, owed a duty to Plaintiff, yet failed to care for her in a manner and in an environment that promoted maintenance or enhancement of her quality of life, as required by 42 U.S.C. §1396r(b)(1)(A), 42 C.F.R. §483.15, and 22 C.C.R. §72315(b). By way of example, the environment the DEFENDANTS, and each of them, provided harmed, not enhanced, Plaintiff’s quality of life by allowing Plaintiff’s weakness to worsen to the point of paralysis.

37. That Defendants, [DEFENDANT NAMES] and DOES 1 through 100, inclusive, and each of them, through their Administrators, failed to screen Plaintiff for admission in order to ensure that the facility admitted only those patients for whom they could provide adequate care as required by 22 C.F.R. §72513(f). By way of example, Defendant intentionally admitted more residents than they could provide care, knowing that they did not have appropriate staff, based on the fact that the Plaintiff’s worsening weakness went unrecognized and untreated and which ultimately resulted in her paralysis.

38. That the DEFENDANTS, and each of them, failed to meet the standard of care and otherwise failed to exercise that degree of care that a reasonable person in a like position would exercise with respect to caring for the Plaintiff by: failing to conduct an ongoing, accurate, and comprehensive assessment of Plaintiff’s needs; failing to develop and/or follow a complete care plan; failing to timely notify a physician and Plaintiff’s legal representative of
material changes in condition and needs; failing to maintain sufficient staff on duty at all times to
meet the needs of their residents, including Plaintiff; and failing to operate the facilities with a
sufficient budget and staff so as to operate in a lawful and safe manner.

39. That the DEFENDANTS and each of their alleged violations of state and federal
laws and regulations as specifically set forth herein are not meant to limit the generality of the
allegations contained herein, but are merely illustrative of the depth of the DEFENDANTS and
each of their malicious, oppressive, fraudulent, and/or reckless conduct.

40. That the laws and regulations set forth herein set the standard of care in the skilled
nursing home and rehabilitation services industry and define the care due to elders, and are
appropriate in determining whether DEFENDANTS and each of their conduct amounted to
physical abuse, neglect, recklessness, oppression, fraud or malice.

41. Based on information and belief, that Defendant, [DEFENDANT NAME], had a
history of providing sub-standard care to residents before and during Plaintiff’s admittance to the
facility as evidenced by deficiency notices received from the State of California’s Department of
Health Services. In spite of receiving deficiency notices, thereby being placed on notice of the
deficiencies and the conduct, and agreeing to a plan of correction to ensure that such conduct
would not reoccur, Defendant, [DEFENDANT NAME], repeated this conduct with regard to
[PLAINTIFF NAME]. This conduct represents intentional and reckless conduct toward
[PLAINTIFF NAME].

42. That Defendant, [DEFENDANT NAME], had a history of providing sub-standard
care to residents before and during Plaintiff’s admittance to the facility as evidenced by the
deficiency notices it received from the State of California’s Department of Health Services.
Specifically, from [DATE] through [DATE], the facility received, among other things, at least
four quality care deficiency notices, at least three resident assessment deficiency notices, and at
least two residents rights deficiency notices. In spite of receiving these deficiency notices,
thereby being placed on notice of the deficiencies and the conduct, and agreeing to a plan of
correction to ensure that such conduct would not reoccur, Defendant, [DEFENDANT NAME],
repeated this conduct with regard to [PLAINTIFF NAME] during the same period. This conduct
represents intentional and reckless conduct toward [PLAINTIFF NAME].

43. That DEFENDANTS and each of their neglect and abuse of Plaintiff was due to the fact that Defendants, and each of them, conceived, implemented, and carried out a scheme to place “profits over people” at the facility, whereby the DEFENDANTS and each of them intentionally underfunded and understaffed the facility in order to decrease expenses and increase profits.

44. That DEFENDANTS and each of them knew that their scheme of promoting profits over people would result in inadequate care and services to their residents and that the underfunding and understaffing posed an extreme risk to the health, safety and welfare of the Plaintiff, as well as the other residents.

45. That as part of their profit scheme, DEFENDANTS and each of them implemented cost cutting measures at the facility, which included failing to adequately train and/or screen existing or incoming staff to ensure that they were competent in meeting the needs of their residents, including Plaintiff. Defendants, and each of them, also retained incompetent service personnel, many of whom were not properly trained or qualified to care for the residents of the facility, including Plaintiff.

46. That DEFENDANTS, and each of them, intentionally underfunded and understaffed the facility in order to maximize profits, even though the Defendants, and each of them, knew that their conduct severely jeopardized the health, safety and welfare of their residents, including Plaintiff.

47. That DEFENDANTS and each of them ratified the conduct of each of their co-defendants in that they mandated, knew, and/or acquiesced to the chronic understaffing, in both number and training, of the facility and were aware that such understaffing and lack of training led to injury to and death of residents of the facility. This awareness is clear by way of the imposition of prior deficiencies by the Department of Health Services. Defendants had notice of the deficiencies and the opportunity to correct them, and yet failed to do so, resulting in the neglect of [PLAINTIFF NAME]. This failure is intentional, willful, malicious and oppressive.

48. That the DEFENDANTS and each of them had within their power, ability and
discretion to mandate that the facility employ adequate staff to meet the needs of their residents, including Plaintiff, yet each of the Defendants intentionally and/or with conscious disregard failed to do so.

49. That the DEFENDANTS and each of them attempted to hide Plaintiff’s serious and deteriorating medical condition, as well as their abuse of Plaintiff, so as not to alert Plaintiff’s family, legal representative, and physician to the fact that the Defendants and each of them had understaffed and underfunded the facility with inadequate and insufficiently trained care personnel.

50. That the physical harm inflicted upon Plaintiff would not have occurred but for the willful disregard by the Defendants and each of their duties to Plaintiff.

51. On [DATE], in accordance with Code of Civil Procedure § 364, Plaintiff gave notice to [DEFENDANT NAME], M.D.; [DEFENDANT NAME], M.D.; [DEFENDANT NAME], M.D.; [DEFENDANT NAMES], named herein by their actual names.

52. This Court is the proper Court, because injury to Plaintiff occurred in its jurisdictional area and because damages exceed the jurisdictional limits of lower courts.

GENERAL ALLEGATIONS OF CIRCUMSTANCES SURROUNDING THE COMPLAINED-OF INJURIES

53. On or about [DATE], Plaintiff, [PLAINTIFF NAME], became a patient of Defendants [DEFENDANT NAME], M.D., [DEFENDANT NAME], M.D.; and [DEFENDANT NAME], M.D.; for treatment of neck and back pain and weakness in her extremities following a fall at her residence.

54. On or about [DATE], Plaintiff underwent nerve conduction testing at the request of Defendant [DEFENDANT NAME], M.D., which revealed significant reduction in nerve signals and indicia of potential spinal cord compromise.

55. On or about [DATE], Plaintiff presented to the emergency room at Defendant [DEFENDANT NAME] with severe pain and weakness, and was not able to walk unassisted. However, she was still able, at this time to [BATHE, DRESS, FEED, TOILET AND GROOM HERSELF], without assistance.
56. Plaintiff was admitted to [DEFENDANT NAME] on DATE and transferred to their rehabilitation unit on or about [DATE], where she remained under their care and custody until [DATE].

57. Plaintiff’s care plan at [DEFENDANT NAME] included both medical treatment and non-medical custodial care. The custodial care of Plaintiff at [DEFENDANT NAME] included, but was not limited to, assistance to Plaintiff to the extent necessary with her activities of daily living [FEEDING, TOILETING, TRANSFERS TO AND FROM HER BED AND WHEELCHAIR, REPOSITIONING WHILE IN BED, BATHING AND GROOMING], and protection from health and safety hazards. Plaintiff was to be provided with these custodial services on a daily basis.

58. During the commission of these custodial care activities over her course at [DEFENDANT NAME], Plaintiff’s increasing inability to perform her activities of daily living was noted in the medical chart by her custodial care providers. However, despite noting the patient’s increasing deficits, there was no seeming comprehension by Plaintiff’s custodial care providers that this increasing inability to perform her basic activities of daily living was indicative of the worsening of Plaintiff’s neurological condition.

59. Moreover, either these observations were not communicated to Plaintiff’s medical providers at all, or they were communicated to her medical providers but ignored.

60. Plaintiff’s deteriorating condition required her custodial care providers to provide increased assistance to Plaintiff with performance of her activities of daily living and protection from health and safety hazards, including but not limited to any activity or exercise or movement (e.g. turning the patient to change her linens) of Plaintiff by the custodial care providers that could result in further harm.

61. However, no modifications to Plaintiff’s care plan were made in light of her deteriorating condition.

62. On at least three occasions, [DATE], the evening shift [DATE] and [DATE], there was a failure by the custodial care staff at [DEFENDANT NAME] to provide custodial care to Plaintiff in the areas of hygiene, safety, activity, and skincare, despite the requirement to
provide this custodial care to Plaintiff on a daily basis.

63. While she was at [DEFENDANT NAME], Plaintiff was not properly assessed or examined or provided with any supportive device or other precautions to protect her compromised spine. Instead, as part of her care regimen, she underwent transfers, stretching and bending exercises, bedrolls, and ambulation exercises while unprotected, and while under pain medications to mask any pain she was experiencing.

64. On or about DATE, Plaintiff was discharged to Defendant [DEFENDANT NAME] for custodial and rehabilitative care. During her stay at [DEFENDANT NAME], Plaintiff was not fully and properly assessed nor provided with any supportive device or other precautions to protect her compromised spine. Instead, Plaintiff was medicated for pain and underwent transfers, stretching and bending exercises, bedrolls, and ambulation exercises while unprotected. Moreover, while she was under the care and custody of this facility, in deliberate disregard of Plaintiff’s physical condition, Plaintiff was berated as malingering by the [DEFENDANT NAME] staff for being unable to complete the physical tasks before her.

65. Plaintiff grew progressively weaker and became unable to move her lower extremities and arm.

66. On or about [DATE], an MRI performed on Plaintiff revealed a 9mm disk herniation from C2-C7 with significant cord compromise, necessitating spinal surgery.

67. Defendants, their employees, agents, staff and non-licensed personnel and each of them, and DOES 1 through 100, Inclusive, were responsible for the health, welfare and caring for Plaintiff, [PLAINTIFF NAME], which included, but was not limited to, observation, attention, examination, evaluation, diagnosis, protection, care and treatment of the Plaintiff herein, assistance in performance of her activities of daily living, including but not limited to feeding, bathing, dressing, elimination/toileting, transfers and ambulation as well as proper administrative and clerical management of her health care, physical well-being and custodial care needs. Defendants, their employees, agents, staff, and non-licensed personnel, and each of them, recklessly failed to properly observe, monitor, care for, protect, and rehabilitate Plaintiff, [PLAINTIFF NAME].
As a result of the reckless failure of Defendants and each of them to properly observe, attend, examine, evaluate, diagnose, protect, and care for the Plaintiff herein, and properly assist in the performance of her activities of daily living, including but not limited to bathing, dressing, elimination/toileting, transfers and ambulation, as well as failure to undertake proper administrative and clerical management of her physical well-being and custodial care needs, Plaintiff suffered severe and permanent neurologic injuries, including but not limited to paraplegia of her lower extremities and arm, and will require 24-hour care for the rest of her life.

**FIRST CAUSE OF ACTION**

**FOR NEGLIGENCE**

(On behalf of Plaintiff, [PLAINTIFF NAME], against All Defendants, and Does 1-100, Inclusive)

Plaintiff, [PLAINTIFF NAME], incorporates and re-alleges by reference all of the allegations contained in Paragraphs 1 through ___ of the General Allegations section of this Complaint, as though fully set forth herein.

During all periods of time during which Plaintiff, [PLAINTIFF NAME], was a patient of Defendants, the defendants, and each of them, agreed to perform and undertook to perform for Plaintiff, [PLAINTIFF NAME], all services necessary to Plaintiff's care, which included, but was not limited to, observation, attention, examinations, evaluations, diagnosis, care and treatment of Plaintiff, [PLAINTIFF NAME], and in so doing, the Defendants, and each of them, established a relationship with Plaintiff, [PLAINTIFF NAME], giving rise to each Defendant’s duty to Plaintiff to provide skillful management of her health conditions, including but not limited to observation, attention, evaluation, examinations, diagnosis, care and treatment of [PLAINTIFF NAME].

Defendants named herein and each of them, and DOES 1 through 100, inclusive, and each of them, breached their duty to Plaintiff, [PLAINTIFF NAME], to provide skillful management of her health conditions, including but not limited to observation, examinations, attention, diagnosis, care and treatment of Plaintiff, [PLAINTIFF NAME].

At all times herein mentioned, Defendants named herein, and Does 1-100, and
each of them, so negligently and carelessly cared for, treated and rendered medical services upon the person and body of the plaintiff and so negligently and carelessly operated, managed, controlled and conducted their services, activities and supervision in connection with Plaintiff's care and treatment, and so negligently and carelessly failed to properly ensure the character, quality, ability and competence of individuals treating patients in said hospital that as a direct and proximate result thereof Plaintiff was caused to and did suffer the injuries hereinafter alleged.

73. During said periods of time herein above alleged, Defendants, and each of them, were negligent, careless and unskillful in their management of the health of Plaintiff, [PLAINTIFF NAME], including but not limited to the observation, attention, examinations, diagnosis, care and treatment that were or should have been provided to Plaintiff, [PLAINTIFF NAME].

74. The negligence of Defendants, and each of them, include but is not limited to the following: (1) negligent failure to timely diagnose, manage, and treat Plaintiff’s condition, including, but not limited to disk herniation; (2) negligent failure to render timely, appropriate and complete treatment of Plaintiff’s condition; (3) negligent failure to timely undertake appropriate courses of action; (4) medical and administrative abandonment of Plaintiff; (5) negligent failure to have adequate staffing to meet reasonably expected medical needs of their patient; (6) negligent failure to properly investigate the competency of physicians and surgeons before reappointing them to the medical staff of the hospital; (7) negligent failure to maintain the highest level of medical care for patients in the hospital and/or rehabilitation facility; (8) negligent failure to protect patients from harm; and (9) negligent failure to evaluate the quality of medical treatment rendered on its premises.

75. Further, during said periods of time, Defendants, and each of them, did negligently and carelessly fail to properly advise, warn or inform Plaintiff, [PLAINTIFF NAME], of any other possible alternative methods of diagnosis or treatment, or of the possible risks attendant to the methods of diagnosis or treatment utilized, thereby failing to obtain a free and informed consent.
76. Further, during said periods of time, Defendants, and each of them, did negligently select, review and supervise their medical staff.

77. Further, during said periods of time, Defendants, and each of them, did negligently and carelessly fail to timely furnish equipment or laboratory, or radiological facilities that were necessary for the skillful care and treatment of Plaintiff, [PLAINTIFF NAME].

78. As a direct and legal result of the aforesaid negligence, carelessness and unskillfulness of Defendants, and each of them, Plaintiff, [PLAINTIFF NAME], has suffered, and will in the future suffer pain, loss of enjoyment of life and other forms of severe mental and emotional distress and anguish.

79. As a further direct and legal result of the aforesaid negligence, carelessness and unskillfulness of Defendants, and each of them, Plaintiff, [PLAINTIFF NAME], suffered physical injury, including but not limited to severe neurological damage and paraplegia. Plaintiff is informed and believes and therefore alleges that said injuries have and will result in profound and permanent impairment.

80. As a further direct and legal result of the aforesaid negligence, carelessness and unskillfulness of Defendants, and each of them, Plaintiff has and will in the future incur expenses for the medical, hospital and related care for Plaintiff, including but not limited to medical care, nursing care, rehabilitation care and attendant care, medical equipment, and home modifications.

81. As a further, direct and legal result of said negligence, carelessness and unskillfulness of the Defendants, and each of them, Plaintiff would be entitled to prejudgment interest under Code of Civil Procedure §998 and Civil Code §3291.

SECOND CAUSE OF ACTION

FOR ELDER ABUSE

(On behalf of Plaintiff, [PLAINTIFF NAME], against Defendants [DEFENDANT NAMES] and Does 1-100, Inclusive)

82. Plaintiff, [PLAINTIFF NAME], incorporates and re-alleges by reference all of the allegations contained in Paragraphs 1 through ___ of the General Allegations section of this Complaint, as though fully set forth herein.
83. That DEFENDANTS, [DEFENDANT NAMES], and each of them, intentionally and/or recklessly caused or permitted Plaintiff to be injured and/or to be placed in a situation such that her health was in danger by failing to have adequately trained staff in sufficient numbers to recognize and appreciate Plaintiff’s worsening condition.

84. That DEFENDANTS, [DEFENDANT NAMES], and each of their conduct, as alleged herein, created circumstances or conditions likely to produce great bodily harm, and DEFENDANTS, [DEFENDANT NAMES], and each of them, willfully caused or permitted Plaintiff to suffer, and inflicted upon her, unjustifiable physical pain and mental suffering.

85. That DEFENDANTS, [DEFENDANT NAMES], and each of their conduct, as alleged herein, constitutes “abuse of an elder or dependent adult” as set forth in Welfare and Institutions Code §15610.07.

86. That DEFENDANTS, [DEFENDANT NAMES], and each of their conduct, as alleged herein, constitutes “neglect” as set forth in Welfare and Institutions Code §15610.07, by failing to provide custodial care to Plaintiff on a daily basis, and by failing to summon medical attention in light of Plaintiff’s deteriorating condition.

87. That DEFENDANTS, [DEFENDANT NAMES], and each of their conduct, as alleged herein, constitutes “physical abuse” as set forth in Welfare and Institutions Code §15610.07.

88. That DEFENDANTS, [DEFENDANT NAMES], and each of their conduct, as alleged herein, constitutes “other treatment with resulting physical harm or pain or mental suffering” as set forth in Welfare and Institutions Code §15610.07, by causing Plaintiff to engage in strenuous physical activity, including stretching, straining, and bending during the commission of transfers, bedrolls, and ambulation exercises with an unsupported, compromised spinal cord. Plaintiff’s custodial care providers rolled Plaintiff to change her linens, and moved patient from bed to wheelchair to bed without taking precautions to protect her unsupported spine. Further, DEFENDANT, [DEFENDANT NAME], inflicted mental suffering on Plaintiff by berating her when she could not complete these exercises due to her condition.

89. That DEFENDANTS, [DEFENDANT NAMES], and each of their conduct, as
alleged herein, constitutes “the deprivation by a care custodian of goods or services that are
necessary to avoid physical harm or mental suffering” as set forth in Welfare and Institutions
Code §15610.07. [DEFENDANT NAME] failed to provide assistance to Plaintiff in the areas
of hygiene, safety, activity and skincare on at least three occasions from [DATE] to [DATE].
Moreover, DEFENDANTS, [DEFENDANT NAMES], and each of them, failed to provide basic
supportive orthotic devices to protect Plaintiff’s compromised spine.

90. At all times herein mentioned, Defendants, [DEFENDANT NAMES], and each of
them, by turns, had care and custody of Plaintiff, [PLAINTIFF], and were her “care custodians”
within the meaning of California Welfare & Institutions Code §15610.17.

91. At all times herein mentioned, Defendants, [DEFENDANT NAMES], and each of
them understood or reasonably should have understood that Plaintiff, [PLAINTIFF NAME],
was an elder adult at all times she was under the care and custody of Defendants and each of
them.

92. At all times herein mentioned, one or more of Defendants, [DEFENDANT
NAMES]’s employees, agents, officers, directors, or managing agents acting in his or her
 corporate and/or employment capacity, recklessly failed to use the degree of care that a
reasonable person in the same situation would have used by, among other things, (1) failing to
provide care for her physical and mental health needs while in their custody; (2) failing to protect
Plaintiff from health and safety hazards in the performance of their custodial obligations to
Plaintiff; (3) failing to provide the very services for which Plaintiff was in their care; (4) failing
to appropriately monitor and observe Plaintiff’s condition; (5) failing to respond appropriately to
Plaintiff’s basic needs and comforts, in deliberate disregard of Plaintiff’s physical condition; (6)
failing to render appropriate and complete treatment of Plaintiff’s condition; (7) recklessly
failing to undertake appropriate courses of action; (8) failing to have adequate staffing to meet
reasonably expected needs of their resident; (9) failing to maintain the highest level of care for
patients in the facility; (10) failing to evaluate the quality of care rendered on its premises; (11)
abandoning Plaintiff; and (12) intentionally and oppressively berating Plaintiff for her physical
limitations.
93. At all times herein mentioned, Defendants, [DEFENDANT NAMES]’s employees, agents, officers, directors, or managing agents acting in his or her corporate and/or employment capacity, acted with recklessness, malice, oppression, and/or fraud.

94. At all times herein mentioned, Defendants, [DEFENDANT NAMES], and each of them, and DOES 1 through 100, inclusive, ratified and/or authorized the acts of its officers, directors, managing agents acting in his or her corporate and/or employment capacity, physicians, nurses, rehabilitation therapists, nutritionists, employees, agents, staff, and other medical and non-medical and/or non-licensed personnel while they attended Plaintiff.

95. As a legal result of the failure of Defendants, [DEFENDANT NAMES]’s employees, agents, officers, directors, or managing agents acting in his or her corporate and/or employment capacity to protect Plaintiff in light of her conditions, and failure to provide adequate custodial care for Plaintiff, [PLAINTIFF NAME], and/or failure to protect Plaintiff, [PLAINTIFF NAME], from health and safety hazards, she suffered damages, including, without limitation, severe neurologic injuries and other general and special damages, all in an amount according to proof at trial.

96. Plaintiff, [PLAINTIFF NAME], was substantially more vulnerable than other members of the public to Defendants, [DEFENDANT NAMES]’s, respective conduct because of her age and physical condition.

97. That as a direct, actual, legal, and proximate cause of DEFENDANTS [DEFENDANT NAME], and each of their conduct, Plaintiff suffered unjustifiable and substantial physical pain and mental suffering and paralysis.

98. That by engaging in the conduct, neglect and abuse, as alleged herein, including but not limited to, the deliberate understaffing of the facility knowing the harm that resulted to other patients during the months immediately before, during, and after the care at issue here, and the profit scheme by which the DEFENDANTS, [DEFENDANT NAMES], and each of them, underfunded and understaffed the facility with personnel adequately trained and qualified to recognize and appreciate Plaintiff’s worsening condition during the provision of their custodial obligations to Plaintiff and take appropriate action, despite the known risk to elder adults,
including Plaintiff, DEFENDANTS and each of their actions were malicious, oppressive and/or reckless.

99. The actions taken by Defendants, [DEFENDANT NAMES], and each of them, as set forth hereinabove, were in all respects malicious, oppressive, despicable, reckless, and manifested a conscious disregard or contempt for the rights of Plaintiff, [PLAINTIFF NAME]. Plaintiff is thereby entitled to an award of heightened damages, including attorneys’ fees, pursuant to Welfare & Institutions Code §15657, in an amount according to proof at trial.

**PRAYER**

WHEREFORE, Plaintiff prays for judgment against Defendants, and each of them, as follows:

**FIRST CAUSE OF ACTION:**

1. General damages according to proof;
2. Special damages according to proof;
3. Legal interest on judgment from the filing of this complaint to the date of judgment; and
4. Any other and further relief as the Court deems just and proper.

**SECOND CAUSE OF ACTION:**

1. General damages according to proof;
2. Special damages according to proof;
3. Legal interest on judgment from the filing of this complaint to the date of judgment;
4. Attorneys’ fees and heightened damages as allowable pursuant to Welfare & Institutions Code §15657; and
5. Any other and further relief as the Court deems just and proper.

Dated: [LAW FIRM NAME]

By: ________________________________

[ATTORNEY NAME]
Attorney for Plaintiff

[PLAINTIFF NAME]
Plaintiff’s Proposed Jury Instructions

[ATTORNEY NAME], SBN: [ATTORNEY NUMBER]
[LAW FIRM NAME]
[ADDRESS]
[CITY], CA [ZIP]
Tel: [PHONE]
Fax: [FAX]

Attorneys for Plaintiffs

SUPERIOR COURT OF THE STATE OF CALIFORNIA
COUNTY OF [COUNTY]

[PLAINTIFF NAME],

Plaintiff,

vs.

[DEFENDANT NAME]; and DOES ONE through FIFTY inclusive,

Defendants.

Plaintiff [PLAINTIFF NAME] respectfully submits the following proposed jury instructions to be used at trial:

Dated: [LAW FIRM NAME]

By: ________________________________
[ATTORNEY NAME]
[LAW FIRM NAME]
[ADDRESS]
[CITY], [STATE] [ZIP CODE]
Attorneys for Plaintiff
PLAINTIFF’S PROPOSED JURY INSTRUCTIONS

100. Preliminary Admonitions

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You have now been sworn as jurors in this case. I want to impress on you the seriousness and importance of serving on a jury. Trial by jury is a fundamental right in California. The parties have a right to a jury that is selected fairly, that comes to the case without bias, and that will attempt to reach a verdict based on the evidence presented. Before we begin, I need to explain how you must conduct yourselves during the trial.

Do not allow anything that happens outside this courtroom to affect your decision. During the trial do not talk about this case or the people involved in it with anyone, including family and persons living in your household, friends and coworkers, spiritual leaders, advisors, or therapists.

This prohibition is not limited to face-to-face conversations. It also extends to all forms of electronic communications. Do not use any electronic device or media, such as a cell phone or smart phone, PDA, computer, the Internet, any Internet service, any text or instant-messaging service, any Internet chat room, blog, or Web site, including social networking websites or online diaries, to send or receive any information to or from anyone about this case or your experience as a juror until after you have been discharged from your jury duty.
Settled Case Checklist

1. Is the case:
   ☐ Medical Malpractice ☐ Personal Injury ☐ Other
2. Will MICRA fee calculation apply?
3. What is the Fee Agreement?
4. Has there been any agreed fee reduction?
5. How Many Plaintiffs?
6. Any Minors?
7. If yes, what are the names and apportionments to each?

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8. If more than one plaintiff: How should fees and all other items be allocated between plaintiffs?
9. Is there a referring attorney?
10. If so, what is their fee percentage?
11. Are there any medical liens?
12. If so, by what entity?
   ☐ Medi-Cal ☐ Medi-Care ☐ ERISA ☐ Private Carrier
13. How much for cost reserve?
14. Have we requested all costs, including those incurred by co-counsel or referring attorney if applicable?
15. Is there any loan payment to be withheld from settlement? (e.g. DeRungs or Green-Stark)
16. Is there going to be any reserve held for prosecuting another related case?
17. Is any part of the settlement going to go to reimbursing a co-plaintiff or GAL for care, services provided, expenses incurred, etc.?
18. Is there a prior attorney with a lien?
19. Is there any part of the settlement going to an annuity?
20. Is there any part of the settlement going to a trust, special needs or other?
21. Is there going to be a trust prep reserve held out of the settlement?
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