

# MEDICAL MALPRACTICE PAYMENT REPORT

Report Number: 550000070365952

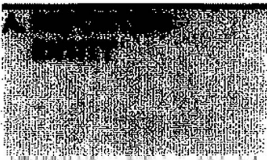
This report is maintained under the provisions of:

Title IV (NPDB)

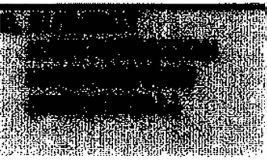
Section 1921 (NPDB)

Section 1128E (HIPDB)

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Title IV of Public Law 99-660, as amended, and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. For additional information or clarification, contact the reporting entity identified in Section A.



Entity Name: PORTLAND VA MEDICAL CENTER  
Address: PO BOX 1034  
City, State, Zip: PORTLAND, OR 97239-9823  
Country:  
Name of Office: MEDICAL PROFESSIONAL SERVICES  
Title or Department: CHIEF OF STAFF  
Telephone: (503) 273-5342  
Entity Internal Report Reference: 09-13  
Type of Report: INITIAL



Subject Name: JUN, WEON  
Other Name(s) Used:  
Gender: MALE  
Date of Birth:  
Organization Name: PORTLAND VA MEDICAL CENTER  
Work Address: 3710 SW U.S. VETERANS HOSP RD  
City, State, ZIP: PORTLAND, OR 97239  
Home Address:  
City, State, ZIP:  
Deceased: NO  
Social Security Numbers (SSN): \*\*\*-\*\*-XXX  
Professional School(s) & Year(s) of Graduation: PACIFIC UNIVERSITY COLLEGE OF OPTOMETRY (1995)  
Occupation/Field of Licensure (Code): OPTOMETRIST (636)  
State License Number, State of Licensure: 2514ATI, OR  
Drug Enforcement Administration (DEA) Numbers:  
Hospital Affiliation(s): VA MEDICAL CENTER  
PORTLAND, OR



Date of Report: 08/30/2011  
Relationship of Entity to This Practitioner: SELF-INSURED ORGANIZATION  
**PAYMENTS BY THIS PAYER FOR THIS PRACTITIONER**  
Amount of This Payment for This Practitioner: \$ 85,000.00  
Date of This Payment: 08/20/2010  
This Payment Represents: A SINGLE FINAL PAYMENT  
Total Amount Paid or to Be Paid by This Payer for This Practitioner: \$ 85,000.00  
Payment Result of: SETTLEMENT  
Date of Judgment or Settlement, if Any: 07/29/2010  
Adjudicative Body Case Number:  
Adjudicative Body Name:  
Court File Number:

DCN: 550000070365952  
Process Date: 08/30/2011  
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JUN, WEON  
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Description of Judgment or Settlement and Any Conditions, Including Terms of Payment: MEDICAL MALPRACTICE CLAIM ALLEGING FAILURE TO DIAGNOSE, REFER AND PROPERLY TREAT A MACULAR HOLE.

**PAYMENTS BY THIS PAYER FOR OTHER PRACTITIONERS IN THIS CASE**

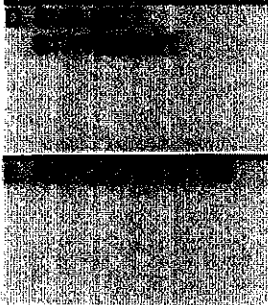
Total Amount Paid or to Be Paid by This Payer for All Practitioners in This Case: \$ 85,000.00  
Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case: 1

**PAYMENTS BY OTHERS FOR THIS PRACTITIONER**

Has a State Guaranty Fund or State Excess Judgment Fund Made a Payment for This Practitioner in This Case, or Is Such a Payment Expected to Be Made?:  
Amount Paid or Expected to Be Paid by the State Fund:  
Has a Self-Insured Organization and/or Other Insurance Company/Companies Made Payment(s) for This Practitioner in This Case, or Is/Are Such Payment(s) Expected to Be Made?:  
Amount Paid or Expected to Be Paid by Self-Insured Organization(s) and/or Other Insurance Company/Companies:

**CLASSIFICATION OF ACT(S) OR OMISSION(S)**

Patient's Age at Time of Initial Event: 72 YEARS  
Patient's Gender: MALE  
Patient Type: OUTPATIENT  
Description of the Medical Condition With Which the Patient Presented for Treatment: PATIENT WITH INCREASING FLOATERS AND PROBLEMS WITH DISTANCE VISION.  
Description of the Procedure Performed: NO PROCEDURES PERFORMED  
Nature of Allegation: TREATMENT RELATED (060)  
Specific Allegation: FAILURE TO TREAT (113)  
Date of Event Associated With Allegation or Incident: 09/12/2006  
Outcome: SIGNIFICANT PERMANENT INJURY (06)  
Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based: MEDICAL MALPRACTICE CLAIM ALLEGING FAILURE TO DIAGNOSE, REFER AND PROPERLY TREAT A MACULAR HOLE. OUTCOME: VISUALLY SIGNIFICANT DISTORTION AND DECREASED ACUITY.



If the subject identified in Section B of this report has submitted a statement, it appears in this section.

Unless a box below is checked, the subject of this report identified in Section B has not contested this report.

- If box is checked, this report has been disputed by the subject identified in Section B.
- If box is checked, at the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.
- If box is checked, at the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services. The Secretary's decision is shown below:

*the* **DataBank**

P.O. Box 10832  
Chantilly, VA 20153-0832

<http://www.npdb-hipdb.hrsa.gov>

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**Process Date:** 08/30/2011  
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**JUN, WEON**  
**For authorized use by:**  
PORTLAND VA MEDICAL CENTER

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Date of Original Submission: 08/30/2011  
Date of Most Recent Change: 08/30/2011

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**END OF REPORT**

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