FILED

APR 08 2009

Carol E. Higbee, P.J.Cv.

IN RE: FOSAMAX LITIGATION	**SUPERIOR COURT OF NEW JERSEY LAW DIVISION: ATLANTIC COUNTY**
	CASE NO. 282
	CIVIL ACTION
APPLIES TO ALL CASES	**ORDER**

THIS MATTER having come before the Court on March 19, 2009, and counsel for plaintiffs and counsel for defendant having been present and for good cause shown,

IT IS on this 8th day of April ____, 2009, **ORDERED** as follows:

1. For all cases filed as of the date of this Order, plaintiffs shall provide completed Plaintiff Profile Forms (annexed hereto as Exhibit 1) by June 1, 2009.

2. For all cases filed after the date of this Order, plaintiffs shall provide a completed Plaintiff Profile Form, no later than 60 days after the date of filing of their complaint.

3. For all cases filed as of the date of this Order and for which a materially completed Plaintiff Profile Form has been produced by June 1, Defendant shall produce completed Merck Case Profile Forms (annexed hereto as Exhibit 2) by August 1, 2009.

4. For all cases filed after the date of this Order, Defendant shall produce completed Merck Case Profile forms, no later than 60 days after receipt of a materially completed, corresponding Plaintiff Profile Form.

5. Defendant shall also produce information regarding advertising for FOSAMAX and FOSAMAX PLUS D including: (a) the identity of the advertising; (b) type of media (e.g., radio, television); (c) media outlet in which the advertising ran; (d) date of advertising; and (e) reasonably available information pertaining to the cost of each advertising campaign. If

Defendant finds that information delineated herein is not reasonably available counsel shall meet and confer to discuss the reason such information is not reasonably available, and if necessary, proposed modification of the production requirements.

6. Within 60 days after receipt of the WAES database production, Plaintiffs shall identify for Defendant the WAES numbers for any FOSAMAX and FOSAMAX PLUS D adverse events for which they are requesting source materials be produced from the DEIOS database. Defendant shall produce such materials as soon as reasonably possible. Plaintiffs are not foreclosed from making subsequent reasonable requests for additional WAES source material productions. The parties shall meet and confer if there are any disputes regarding the scope of adverse events for which source materials are requested.

Honorable Carol E. Higbee, P.J. Cv.

Exhibit 1

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY

IN RE: FOSAMAX LITIGATION	)	
CASE NO. 282	)	
CIVIL ACTION	)	**Plaintiff:** _____
	)	**Docket No.** _____

PLAINTIFF PROFILE FORM

Please provide the following information regarding yourself or each individual on whose behalf a personal injury claim is being made. Each question must be answered in full. If you do not know or cannot recall the information needed to answer a question, please indicate that in response to the question. To the extent you cannot completely answer any question, please provide whatever information is available to you and, as to any information sought by the question which you do not know, please identify what part of the question you cannot answer. Do not leave any questions unanswered or blank.

Please attach as many sheets of paper as necessary to fully answer these questions.

In filling out this form, please use the following definitions:

(1) "**health care provider**" or "**health care practitioner**" means any hospital, clinic, center, physician's office, dentist's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dental, oral, psychiatric, mental, emotional or psychological care or advice, and any doctor, physician, surgeon, oncologist, radiologist, dentist, oral and maxillofacial surgeon pathologist, oral pathologist, natural health provider, homeopath, osteopath, chiropractor, paramedic, nurse (registered or otherwise), physiotherapist, psychologist, psychiatrist, therapist, or any other person practicing any healing art, or performing any physical, dental, oral, radiological, or mental evaluation or examination or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you;

(2) "**document**" means any writing or record of every type that is in your possession or the possession of your counsel, including but not limited to written documents, e-mails, cassettes, videotapes, photographs, charts, computer discs or tapes, x-rays, drawings, graphs, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into any reasonably usable form.

(3) "**Fosamax**" means FOSAMAX® and FOSAMAX PLUS D®.

(4) "**Osteonecrosis of the jaw**" includes "avascular necrosis of the jaw," "aseptic necrosis of the jaw," and "ischemic necrosis of the jaw."

Other than in Section I(C), those questions using the term "You" should refer to the person who used Fosamax. You should attach as many sheets of paper as necessary to fully answer these questions.

If you have any documents (as defined above), that you are requested to produce in response to questions in this profile form or that relate to Fosamax or other bisphosphonate-containing products or medications you allegedly took, or to the incident, injuries, claims or damages that are the subject of your complaint or, if you have any unused Fosamax and its accompanying packaging, you are required to give all of these documents and materials to your attorney as soon as possible. If you are unclear about this obligation, please contact your attorney.

Whenever you are asked for the name and address of an individual or entity, you are to provide the full name and complete address for that individual or entity.

I. CASE INFORMATION

A. Name of person completing this form_____

B. Please state the following for the civil action which you have filed:

1. Case Caption: _____

2. Docket No.: _____

3. Please state the name, address, and telephone number of the principal attorney representing you:

_____
Name of attorney

_____
Firm name

_____
City, State and Zip Code

_____
Telephone number

C. If you are completing this questionnaire on behalf of someone else (*e.g.*, a deceased person, an incapacitated person), please complete the following:

_____
Your Name

_____
Address

_____
Social Security Number
In what capacity are you representing the individual? _____

_____

If you were appointed by a court, please provide a copy of the order of appointment or power of attorney/authorizing document and state the:

_____

Court Date of Appointment

What is your relationship to the deceased or represented person? ____

_____

If you represent a decedent's estate, state the date of the decedent's death:_____

D. Claim Information

1. Do you claim that you have suffered a physical injury as a result of Fosamax use? Yes _____ No _____

2. If the answer to the foregoing question is "yes," state the nature of the physical injury or injuries which you claim.
   ___ Osteonecrosis of the Jaw
   ___ Osteomyelitis of the Jaw
   ___ Increased Risk of Developing Osteonecrosis of the Jaw
   ___ Other (Please Specify): _____
   ___ Not claiming any physical injuries as a result of Fosamax use

   a. When do you claim this injury occurred?_____
   (month/day/year)

   b. Date of diagnosis: _____
   (month/day/year)

   c. Name, address, telephone number and specialty of the person who diagnosed this injury: _____
   _____
   _____

   d. Name, address, telephone number and specialty of the person who treated this injury: _____
   _____
   _____

3. Do you claim that you have suffered a psychological or emotional injury as a result of Fosamax use? Yes _____ No _____

4. If the answer to the foregoing question is "yes," state the nature of the psychological or emotional injury or injuries which you claim.
   ___ Depression
   ___ Anxiety
   ___ Other (Please Specify): _____
   ___ Not claiming any psychological or emotional injury as a result of Fosamax use

   a. When do you claim this injury occurred?_____
   (month/day/year)

b. Have you sought treatment for this psychological or emotional injury? Yes ____ No ____

c. Symptom(s):

_____

_____

d. Date(s) of onset: _____

e. Date of diagnosis: _____
(month/day/year)

f. Do you still have the injury? Yes ____ No _____

g. Name, address, telephone number and specialty of the person who first diagnosed this injury. _____

_____

_____

h. Name, address, telephone number and specialty of the person who treated this injury:_____

_____

_____

i. Medications prescribed or recommended:_____

_____

_____

j. Date(s) of treatment: _____

5. Have you had discussions with any physician(s), dentist(s), or other health care provider(s) about whether any injury described in section I(D) above is related to the use of Fosamax?

Yes _____No _____

If "yes," please identify:
Name(s) of health care provider(s):_____
Address(es):_____
Specialty:_____
Date(s) of Discussion(s):_____

a. Do you recall what you were told? Yes _____ No_____

b. **If "yes,"** what were you told? _____

_____

_____

_____

_____

[If you discussed with more than one health care provider, please separately identify what each individual said to you]

6. Do you claim that your treatment with Fosamax increased your risk of a future injury or harm that you have not yet experienced?
Yes _____ No _____

If "yes," identify and describe each and every such future injury or harm and for each, identify the basis for your contention._____
_____
_____

7. Have you had any discussions with any physician(s), dentist(s), or other health care provider(s) about whether your treatment with Fosamax or any other bisphosphonate puts you at increased risk of future injury or harm?
Yes _____ No _____ Don't Recall _____

If "yes," please identify:
Name of heath care provider(s):_____
Address:_____
Specialty:_____
Date(s) of Discussion(s):_____
State what the health care provider told you, including any description of the future injury or harm: _____
_____
_____
_____
_____

[If you discussed with more than one health care provider, please separately identify what each individual said to you]

8. If you do not claim to have suffered a physical, psychological, or emotional injury as a result of Fosamax use, state how you have been injured or damaged.
_____
_____
_____

II. PERSONAL INFORMATION OF THE PERSON WHO USED FOSAMAX

A. Name: _____

B. Maiden name(s) or any other name(s) by which you have been known (from prior marriages or otherwise, if any): _____

C. Gender: Male _____ Female _____

D. Social Security number: _____

E. Driver's license number: _____
State of issuance: _____

F. Date and place of birth (city, county, and state): _____
_____

G. Provide the full name, address, and age of each of your children: _____

_____

_____

H. Identify each address at which you have resided during the last ten (10) years, and list when you started and stopped living at each one:

Address	Dates of Residence

I. Complete the following information with respect to your employment for ten (10) years prior to your use of Fosamax or any other bisphosphonate to the present (If not employed during that period, state last employer).

Employer	Address	Occupation/ Job Duties	Dates of Employment	Salary/ Bonus/ Overtime

J. Within the last ten (10) years, have you been convicted of any felony or a crime involving dishonesty or false statement?
Yes _____ No _____

If "yes," please (1) identify the crime and/or felony, (2) when you were convicted or pled guilty, (3) where you were convicted or pled guilty, (4) whether you were incarcerated, and if so, for how long you were incarcerated.

_____

_____

_____

K. Are you making a claim for lost wages for either your present or previous employment? Yes ____ No ____

If "yes," identify your annual income at the time of the injury alleged in Section I(D): _____

L. Have you ever filed a lawsuit or brought any other type of legal claim aside from the present suit? Yes _____ No _____

If "yes," for each such lawsuit, state (1) the court in which such lawsuit was filed, (2) the case name, (3) the names of the adverse parties, (4) the civil action or docket number assigned to the lawsuit, (5) a description of your claims in the lawsuit, and (6) whether the lawsuit has been resolved and if so, how it was resolved._____

_____

_____

_____

M. Have you ever served in any branch of the U.S. Military? Yes ____ No ____

If "yes," please state:

1. What branch and the dates of service:_____
2. Were you discharged for any reason relating to your physical, psychiatric or emotional condition? Yes ____ No ____
   If **"yes,"** state what that condition was:_____
   _____
3. Have you ever been rejected from military service for any reason relating to your health or physical condition? Yes ____ No ____
   If **"yes,"** state what that condition was:_____
   _____
4. Have you ever served in the military overseas? Yes ____ No ____
   If **"yes,"** state location and dates:_____
   _____

N. Insurance / Claim Information

1. Have you ever filed a worker's compensation claim? Yes ____ No ____

   If "yes," to the best of your knowledge please state:

   a. Year claim was filed: _____
   b. Nature of disability: _____
   c. Approximate dates of disability: _____
   d. Resolution of claim: Denied ____ Granted ____ Other ____
      If "other," describe: _____
   e. Identify the full name and address of the entity most likely to have records concerning your claim: _____
   f. Full name and address of your employer against whom claim was filed:_____
      _____

2. Have you ever filed a social security disability (SSI or SSD) claim? Yes ____ No ____

   If "yes," to the best of your knowledge please state:

   a. Year claim was filed: _____
   b. Nature of disability: _____
   c. Approximate dates of disability: _____
   d. Resolution of claim: Denied ____ Granted ____ Other ____

If "other," describe: _____

e. Identify the full name and address of the entity most like to have records concerning your claim: _____

_____

3. Has any insurance or other company provided medical and/or dental coverage to you (either directly or through a group or employer) for the period beginning twelve (12) years before your first use of Fosamax or any other bisphosphonate through the present? Yes _____ No _____ Don't Recall _____

If "yes," then as to each such company, separately state:

a. Name of the company: _____

b. Address of the company: _____

_____

c. The account/policy number or designation: _____

d. Name of Primary Insured: _____

e. Dates of coverage: _____

f. It there are any insurance coverages for which you cannot recall all of the details, please describe those details that you can remember: ____

_____

_____

_____

III. EDUCATIONAL HISTORY

Identify each school, college, university and other educational institution you have attended, the dates of attendance, courses of study pursued and diplomas or degrees awarded. _____

_____

_____

_____

_____

_____

IV. FAMILY INFORMATION

A. Have you ever been married?
Yes _____ No _____

B. **If "yes,"** for each spouse/former spouse state:

1. Spouse's name: _____

2. Dates of marriage: _____

3. Spouse's date of birth: _____

4. Spouse's occupation: _____

5. Spouse's address and phone number: _____

_____

6. If applicable, why did the marriage end (*e.g.*, divorce, death)? _____

_____

7. If applicable, the date the marriage ended: _____

C. Have your grandparents, parents, siblings and children ever had or been diagnosed with or had osteonecrosis or osteomyelitis?
Yes _____ No _____

If "yes," state (1) the name and relationship of the person to you, (2) the disease(s) he or she has/had, and (3) the date of that individual's diagnosis. ___

_____

_____

V. DENTAL BACKGROUND FOR JAW RELATED INJURY CLAIMS

Please complete this section if you are claiming any jaw-related injury or you are claiming that you are at risk of any future jaw-related injury. If you are not claiming any such injury, please complete Section V (alternate) beginning on p. 13 below.

A. HABITS

1. On average, during the twelve (12) year period BEFORE you first used Fosamax, how often did you:

   a. Brush your teeth per week? _____

   b. Floss your teeth per week? _____

   c. See a dentist for routine check-ups, examinations or teeth cleaning? _____

   _____

2. On average, during the period AFTER you began using Fosamax, how often do you:

   a. Brush your teeth per week? _____

   b. Floss your teeth per week? _____

   c. See a dentist for routine check-ups, examinations or teeth cleaning? _____

   _____

B. DENTAL STATUS

1. Are you missing any teeth (including wisdom teeth or others)?

Yes _____ No _____ Don't Recall _____

If "yes," indicate the following:

a. How many are you missing? _____

b. Which teeth? _____

c. When and how did you lose each of those teeth? _____

_____

2. Were any of the missing teeth extracted? Yes _____ No _____ Don't Recall _____

If "yes," indicate the following:

a. How many? _____

b. Which teeth? _____

_____

c. When and why were these teeth extracted? _____

_____

d. Who performed each extraction? (please provide the name, address, telephone number and specialty of the person who performed each extraction(s)). _____

_____

_____

3. Have you ever had any dental implants, artificial fixtures (including dentures and bridges), or any dental prosthodontics or orthodontia (including braces)? Yes _____ No _____ Don't Recall _____

If "yes," indicate the following:

a. What type of dental implant(s), artificial fixture(s), or dental prosthodontics or orthodontia did you have? _____

_____

_____

b. Identify approximately when you received each dental implant, artificial fixture, or dental prosthodontics or orthodontia? _____

_____

_____

c. Please identify the teeth or the approximate locations in your mouth where you received dental implants, artificial fixtures, or dental prosthodontics or orthodontia? _____

_____

_____

d. Please provide the name, address, telephone number and specialty of the persons who installed or fitted your dental implants, artificial fixtures, or dental prosthodontics or orthodontia. _____

_____

_____

_____

e. Please describe any problems or complications you experienced relating to the dental implants, artificial fixtures, or dental prosthodontics or orthodontia you received? _____
_____
_____

4. Have you ever had any periodontal procedures? Yes ____ No _____ Don't Recall _____

If "yes," indicate the following:

a. What type of periodontal procedure(s) have you had? _____
_____

b. When did you receive each procedure? _____

c. Please provide the name, address, telephone number and specialty of the person who performed each procedure. _____
_____
_____

d. Did you have any problems or complications related to the periodontal procedure (describe each complication)? _____
_____
_____

5. Have you ever had a fracture of the jaw? Yes ____ No _____ Don't Recall _____

If "yes," indicate the following:

a. Date(s) of each fracture?_____

b. Describe how you suffered each fracture?_____
_____

c. Describe the portion(s) of the jaw fractured and the extent of the fracture(s):_____
_____

d. Please provide the name, address, and telephone number of each person who treated you for each fracture. _____
_____

C. Have you ever had or been diagnosed with any of the following conditions:

	Yes	No	Unknown
Osteonecrosis of the jaw			
Osteomyelitis			
Infection in the mouth			
Tori in the mouth			
Bone spurs in the mouth			
Exposed bone in the mouth			
Tooth decay			

[illegible]	Yes	No	Unknown
Poor healing of infections in the mouth			
Gum disease or infection			
Periodontal disease			
Bleeding gums			
Temporomandibular joint [TMJ] problems			
Abscesses			
Lesions in the mouth			
Cancer of the mouth			
Herpes [in or around the mouth]			
Lockjaw			
Exostosis (bony outgrowth)			
Pain (persistent or otherwise) in the mouth or jaw			
Swelling in the mouth or jaw			
Non-healing sore in the mouth or jaw			
Draining fistula			
Numbness of the lip, chin, mouth or jaw			
"Heaviness" of the jaw			
Burning or tingling in the jaw			
Limited range of motion in the jaw			
Edentulous (toothless) regions in the mouth			
Lingual Mandibular Sequestration			
Osteoradionecrosis			
Other disease of the jaw or oral cavity Please specify: _____			

D. If you responded "**yes**" to any of the above, please provide the following information for each condition:

Condition	**Name and Address of Person(s) Who Diagnosed or Treated the Condition**	**Approximate Onset Date of Condition**

E. State whether you ever had any of the following dental or oral procedures/tests at any time.

	Yes	No	Unknown

	Yes	No	Unknown
Gingivectomy or gum resection			
Periodontal surgery			
Oral surgery			
Root canal or other endodontic procedure			
Root planing, scaling, or other treatment for gum disease			
Any invasive dental procedure			
Ridge smoothing			
Debridement of the oral cavity			
Bone trimming			
Apicoectomy			
Bone jaw biopsy			
Dental x-rays, panorexes, or other dental imaging			
Other diagnostic test or imaging of the mouth or jaw Please specify: _____			

F. For each procedure/test for which you answered "yes," please identify the following information:

Test/Procedure	Name and Address of Physician/Dentist Who Performed Test/Procedure	Approximate Dates of Treatment

V (ALT). DENTAL BACKGROUND FOR NON-JAW RELATED INJURY CLAIMS

Complete this section (Section V (alt.)) only if you did not complete Section V above.

A. DENTAL STATUS

1. Are you missing any teeth (including wisdom teeth or others)?
   Yes _____ No _____ Don't Recall _____
   If "yes," indicate the following:
   a. How many are you missing? _____
   b. Which teeth? _____
   c. When and how did you lose each of those teeth? _____
   _____

2. Were any of the missing teeth extracted? Yes _____ No _____
Don't Recall _____

If "yes," indicate the following:

a. How many? _____

b. Which teeth? _____

_____

c. When and why were these teeth extracted? _____

_____

d. Who performed each extraction? (please provide the name, address, telephone number and specialty of the person who performed each extraction(s)). _____

_____

_____

3. Have you ever had any dental implants, artificial fixtures (including dentures and bridges), or any dental prosthodontics or orthodontia (including braces)? Yes _____ No _____ Don't Recall _____

If "yes," indicate the following:

a. What type of dental implant(s), artificial fixture(s), or dental prosthodontics or orthodontia did you have? _____

_____

_____

b. Identify approximately when you received each dental implant, artificial fixture, or dental prosthodontics or orthodontia? _____

_____

_____

c. Please identify the teeth or the approximate locations in your mouth where you received dental implants, artificial fixtures, or dental prosthodontics or orthodontia? _____

_____

_____

d. Please provide the name, address, telephone number and specialty of the persons who installed or fitted your dental implants, artificial fixtures, or dental prosthodontics or orthodontia. _____

_____

_____

_____

e. Please describe any problems or complications you experienced relating to the dental implants, artificial fixtures, or dental prosthodontics or orthodontia you received? _____

_____

_____

4. Have you ever had any periodontal procedures? Yes ____ No _____
Don't Recall _____

If "yes," indicate the following:

a. What type of periodontal procedure(s) have you had? _____
_____

b. When did you receive each procedure? _____

c. Please provide the name, address, telephone number and specialty of the person who performed each procedure. _____
_____
_____

d. Did you have any problems or complications related to the periodontal procedure (describe each complication)? _____
_____
_____

5. Have you ever had a fracture of the jaw? Yes ____ No _____
Don't Recall _____

If "yes," indicate the following:

a. Date(s) of each fracture?_____

b. Describe how you suffered each fracture?_____
_____

c. Describe the portion(s) of the jaw fractured and the extent of the fracture(s):_____
_____

d. Please provide the name, address, and telephone number of each person who treated you for each fracture. _____
_____

B. State whether you ever had any of the following dental or oral procedures, treatments, or tests at any time.

	Yes	No	Unknown
Gingivectomy or gum resection			
Periodontal surgery			
Oral surgery			
Root canal or other endodontic procedure			
Root planing, scaling, or other treatment for gum disease			
Any invasive dental procedure			
Ridge smoothing			
Debridement of the oral cavity			
Bone trimming			
Apicoectomy			
Bone jaw biopsy			

	Yes	No	Unknown
Intravenous antibiotics to treat a dental infection			

C. For each procedure/test for which you answered "yes," please identify the following information:

Test/Procedure	Name and Address of Physician/Dentist Who Performed Test/Procedure	Approximate Dates of Treatment

VI. OTHER MEDICAL BACKGROUND AND INFORMATION

A. To the best of your knowledge, did you use or take any of the following medications or substances BEFORE the injury that you allege you suffered occurred? **If "yes,"** please provide the first and last date on which you took the medication or substance.

	Yes	No	Date First Taken	Date Last Taken
Corticosteroids or other steroids				
Radiation therapy				
a. Head and/or Neck				
b. Other Body Part				
Chemotherapy				
Hormonal therapy (including, but not limited to, estrogen therapy, oral contraceptive, estrogen/progestin therapy, anti-estrogens, aromatase inhibitors, and anti-androgens/androgen deprivation therapy)				
Blood pressure (hypertension) medication				
Cholesterol-lowering medication				
Medication for the treatment of Rheumatoid Arthritis				
Medication for the treatment of Diabetes				
Selective Estrogen Receptor Modulators (SERMs), such as tamoxifen, Evista (raloxifene), Fareston (toremifene)				

B. Were you taking any other prescription medicines in the five (5) years prior to developing the injury you are claiming in this action?
Yes _____ No _____

If "yes," please list the medications, the first and last dates of ingestion, and reasons for taking each. _____
_____
_____

C. Have you participated in any clinical trials or taken any experimental drugs?
Yes _____ No _____

If "yes," please indicate when you participated in such trials, where the trials took place, which drugs you took, and for what condition you took such drugs. _____
_____
_____
_____
_____

D. Smoking/Tobacco Use History:

Do you now or have you ever smoked or used tobacco products?
Yes_____ No _____
If "yes," indicate with an "X" the answer and fill in the blanks applicable to your history of smoking and/or tobacco use

1. Current smoker of cigarettes ____; cigars ____; pipe tobacco ____; or user of chewing tobacco/snuff ____.
   a. Amount smoked or used: on average _____ per day for _____ years.
2. Past smoker of cigarettes ____; cigars ____; pipe tobacco ____; or used chewing tobacco/snuff ____.
   a. Date on which smoking/tobacco use ceased: _____
   b. Amount smoked or used: on average _____ per day for _____ years.

E. Alcoholic Beverage Consumption History

Do you now drink or have you in the past drunk alcohol (beer, wine, whiskey, etc.)? Yes ____ No ____
If "yes," fill in the appropriate blank with the number of drinks that represents your average alcohol consumption during the period you were taking Fosamax up to the time that you sustained the injuries alleged in the complaint:

_____ drinks per week,
_____ drinks per month,
_____ drinks per year, ***or***

Other (describe): _____

F. Have you ever experienced or been diagnosed or treated for any of the following:

	Yes	No	Unknown
1. Necrosis, avascular necrosis, aseptic necrosis or osteonecrosis in any part of the body			
2. Osteoporosis			
3. Paget's disease			
4. Pancytopenia or abnormal blood count secondary to cancer and/or cancer treatment			
5. Sickle cell disease			
6. Gaucher's disease			
7. Vascular diseases, problems, or insufficiencies			
8. Autoimmune or connective tissue disorders			
a. Systemic lupus erythematosus			
b. Rheumatoid arthritis			
c. Vasculitis			
d. Crohn's disease			
e. Reynaud's syndrome			
f. Sjogren's syndrome			
g. IBD (Inflammatory Bowel Disease)			
h. Pernicious Anemia			
i. Primary Biliary Cirrhosis			
j. Other (describe): _____			
9. Acquired Immune Deficiency Syndrome (AIDS) or HIV			
10. Renal transplant, disease and/or impairment			
11. Caisson's disease,barotraumas and/or decompression sickness			
12. Pancreatitis			
13. Diabetes Mellitus			
14. Fungal infections (including, but not limited to, Aspergillis fungus)			
15. Asthma			
16. Blood disorders, dyscrasias or other blood abnormalities			
17. Dislocation of any bones in the jaw			
18. Bone disorders and/or fractures			
19. Herpes Zoster			
20. Any other liver or kidney disease(s) not mentioned above. Please specify: _____			
21. Hypothyroidism or hypoparathyroidism			

G. If you responded "**yes**" to any of the above, please provide the following information for each condition:

Condition	Name and Address of Person(s) Who Diagnosed or Treated Condition	Approximate Onset Date of Condition

H. If you are claiming a psychological or emotional injury in this case, state whether you have ever experienced or have ever been treated for any psychological, psychiatric or emotional problem (including depression) not related to your use of Fosamax.

Yes _____ No _____

If "yes," please provide the following information for each condition:

1. Describe the symptoms experienced. _____
_____
2. Please provide the name, address, telephone number and specialty of the person who provided the diagnosis and/or treatment. _____
_____
3. Please provide the name and address of the facility or hospital, if any, where the treatment was provided. _____
_____
4. For each provider of care identified in subparagraphs 2 and 3, please produce an executed copy of the release form attached as Ex. C, authorizing Merck to obtain your psychotherapy notes and related records generated by any such mental health care practitioner.

I. Have you ever suffered any injury to your head, neck, mouth or jaw?
Yes _____ No _____

If "yes," please state:

1. When the injury occurred. _____
2. The nature of the injury, including what part of the body was injured.
_____
3. Please provide the name, address, telephone number and specialty of the person who provided the diagnosis and/or treatment._____
_____
_____
4. Please provide the name and address of the facility or hospital, if any, where the treatment was provided. _____
_____

5. Please identify the medications taken to treat the injury. _____

VII. CANCER BACKGROUND

A. Have you ever been diagnosed with cancer or metastatic disease?
Yes _____ No _____

If "yes":

1. When were you first diagnosed with cancer or metastatic disease?

2. What type of cancer or metastatic disease was it? _____

3. Who diagnosed this cancer or metastatic disease? (Please provide the name, address, telephone number and specialty of each diagnosing physician). _____

4. Have you been diagnosed with cancer or metastatic disease more than once? Yes _____ No _____

   If "yes," provide the information requested in questions 1, 2, and 3 for each cancer or metastatic disease diagnosed. _____

VIII. FOSAMAX AND OTHER BISPHOSPHONATE USE

A. Identify which of the following medications you have taken:

	Yes	No
1. FOSAMAX®		
2. FOSAMAX PLUS D®		
2. Zometa®		
3. Aredia®		
4. Reclast®		
5. Actonel®:		
6. Boniva® or Bondronat®		
7. Didronel®		
8. Skelid®		
9. Nerixia®		
10. Bonefos® or Clastoban® or Clasteon® or Ostac®		
11. Osteolite®		

B. Complete the following information for each drug identified above:

Dates of Use of Drug (month/day/year)	Dose and Form of Dose (IV, oral)	Full Name of Physician(s) Who Prescribed	Full Address of Prescribing Physician(s)	Condition(s) Treated	Name of Facility and Street Address of Location Where Drug Was Infused, Injected or Taken or Name and Address of Pharmacy(s) Where Prescription was Filled

C. For what disease or condition were you prescribed each of the medications identified in section VIII(A):

1. Injury, illness, or disability:_____

2. Date(s) of onset:_____

3. Date(s) of diagnosis:_____

4. Please provide the name, address, telephone number and specialty of the person by whom the injury, illness or disability was first diagnosed.

5. List the treatment (surgery, medications taken or prescribed) for the injury, illness or disability._____

D. Did you receive any samples of Fosamax? Yes ____ No ____

If "yes," provide the following:

1. Identify the full name and address of each person who provided them:

2. Identify the approximate date(s) when the samples were provided: ___

E. At the time you first began taking Fosamax or other bisphosphonates did you suffer from any other physical injuries, illnesses or disabilities other than the disease or condition identified in VIII(C) above? Yes _____ No _____

If "yes," identify the injury, illness, or disability, symptoms, date(s) of onset and dates(s) of diagnosis

1. Injury, illness, or disability:_____
_____
_____
2. Symptom(s):_____
_____
3. Date(s) of onset:_____
_____
4. Date(s) of diagnosis:_____
_____
5. Please provide the name, address, telephone number and specialty of the person by whom the injury, illness or disability was first diagnosed. _____
_____

F. To the best of your knowledge, state whether you underwent any of the following tests, procedures, or surgeries BEFORE the injury you allege you suffered occurred.

	Yes	No	Unknown
1. Skeletal bone scan (scintigraphy), Dual Energy X-Ray Absorptiometry (DEXA) scan, or nuclear medicine imaging			
2. MRI (including functional MRI, or MRI spectroscopy), CT or CTA scans for bone			
3. Doppler scans			
4. Ultrasound for bone			
5. PET scans for bone			
6. Interventional radiology procedure images, such as organ procedures or vascular interventional radiology procedures			
7. Vascular surgery			
8. Any other surgery on bone (Please describe: _____)			

G. For each test, procedure, or surgery for which you answered "yes," please identify the treating physician and approximate date of the test.

Test/Procedure	Name and Address of Facility Where Test/Procedure Performed	Approximate Dates of Test/Procedure

H. Did you see any written, televised or internet-based advertising or labeling materials regarding Fosamax prior to or during the time you took Fosamax? Yes _____No _____

If "yes," state which written, televised or internet-based advertising or labeling materials you recall seeing regarding Fosamax and when you saw such advertising or labeling materials, excluding any such materials that are covered by the Attorney-Client or Work Product Privileges._____

_____

_____

I. Have you ever visited any website (including any chat rooms) regarding Fosamax or any other bisphosphonates? Yes _____ No _____

If "yes," identify all websites and chat rooms visited that you recall and the approximate dates of visit, excluding any such visits that are covered by the Attorney-Client or Work Product Privileges.

_____

_____

_____

J. Instructions or Information:

1. Did you receive any written or oral instructions or information about Fosamax before you took it? Yes ____ No ____ Don't Recall _____
2. **If "yes,"** please answer the following:
   a. When did you receive the instructions or information?_____

   _____

   b. From whom did you receive it?_____

   c. What written instructions or information did you receive? _____

   _____

   d. What oral instructions or information did you receive? _____

   _____

IX. MONETARY LOSS CLAIMS

A. Have you paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of Fosamax and for which you seek recovery in the action you have filed?

Yes _____ No _____

If "yes," state the total amount of such expenses at this time: $_____

B. Has your insurer, or any other entity or person, paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of Fosamax and for which you seek recovery in the action you have filed?
Yes _____ No _____

If "yes," state the total amount of such expenses at this time: $_____
Please provide an itemized statement of the nature and amount of all damages you are claiming. _____
_____
_____

X. WITNESSES

Please identify all persons (not identified elsewhere in this questionnaire) who you believe possess information concerning your injury, your current medical condition, the medical condition for which you took Fosamax, and/or your claims in this case and for each, state their name, address, telephone number and a description of the information you believe they possess._____
_____
_____
_____
_____
_____
_____

XI. DOCUMENTS AND THINGS

Please indicate whether you or your attorney are in possession of the following documents by checking "Yes" or "No" where indicated and attach copies of the following documents to your response to this profile form. If you withhold a document or information otherwise discoverable by claiming that it is privileged or otherwise protected, you shall make any such claim expressly and describe the nature of the information or document not produced or disclosed in a manner that enables other parties to assess the applicability of the privilege or protection, in accordance with the requirements of Fed.R.Civ.P. 26(b)(5).

A. For each health care practitioner who has examined you, treated you, or consulted with other health care practitioners regarding your medical or dental condition within twelve (12) years of your first use of Fosamax to the present, produce an executed copy of the release form attached to this Plaintiff's Profile Form as Ex. A, authorizing Merck to obtain medical records from each health care practitioner.

B. Produce an additional TEN ORIGINAL SIGNED copies of the release form attached as Ex. A, leaving blank the name to whom the release is directed, authorizing Merck to obtain medical records from each health care practitioner who later becomes known to Merck who has examined you,

treated you, or consulted with other health care practitioners regarding your medical or dental condition at any time.

C. For each hospital, clinic or any other facility at which you have been treated for any medical or dental condition within twelve (12) years of your first use of Fosamax to the present, produce an executed copy of the release form attached as Ex. A, authorizing Merck to obtain medical records from each such hospital, clinic or any other facility.

D. Produce an additional TEN ORIGINAL SIGNED copies of the release form attached as Ex. A, leaving blank the name to whom the release is directed, authorizing Merck to obtain medical records from any hospital, clinic or any other facility that later becomes known to Merck and at which you have been treated for any medical or dental condition at any time.

E. Has any health care practitioner examined you, treated you, or consulted with other health care practitioners regarding your medical, dental or mental condition at or in affiliation with a Veteran's Administration facility?
Yes_____ No_____

If your answer is YES, please produce an executed copy of the release form VA 10-5345 attached as Ex. B, authorizing Merck to obtain medical records from each health care practitioner.

F. Has any psychologist, psychiatrist or other mental health care practitioner examined or treated you for any psychological, psychiatric, or emotional injuries, illnesses and/or conditions allegedly suffered as a result of your treatment with Fosamax? Yes_____ No_____

If your answer is YES, please produce an executed copy of the release form Authorization for Release of Mental Health Records attached as Ex. C, authorizing Merck to obtain your mental health records, psychotherapy notes, and clinical information generated by any such mental health care practitioner.

G. A copy of all medical records from any health care provider identified in any of your responses to the questions above. Yes ____ No ____

H. All radiological or other imaging or recordings identified in any of your responses to the questions above. Yes ____ No ____

I. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding. Yes ____ No ____

J. Have you ever made a claim for Social Security benefits, disability insurance benefits, or workers' compensation benefits? Yes_____ No_____

If your answer is YES, please produce an executed copy of each applicable authorization (Form SSA-3288; Authorization for Release of Disability Insurance Records; and/or Authorization for Release of Workers' Compensation Records) attached as Ex. D, authorizing Merck to obtain all documents discussing, describing or memorializing your requests for Social Security, disability insurance, or workers' compensation benefits.

K. If you claim you have suffered a loss of earnings or earning capacity, produce copies of your Federal and State income tax returns and related tax forms (such as W-2s, 1099's, etc.) evidencing all income for each of the years from ten (10) years prior to your injury to the present. Yes ____ No ____

L. Do you claim you have suffered a loss of earnings or earning capacity? Yes_____ No_____

If your answer is YES: please produce executed copies of each of the authorizations (Form 4506 and Authorization for Release of Department of Revenue Records) attached as Ex. E, authorizing Merck to obtain your Federal and State income tax returns for each of the years from ten (10) years prior to your injury to the present.

M. If your answer to Question L is YES, please also produce an executed copy of the authorization Form SSA 7050-F4 attached as Ex. F, authorizing Merck to obtain your earnings information from the Social Security Administration.

N. If you claim you have suffered a loss of earnings or earning capacity, all documents relating to your employment at any time, including documents relating to attendance, leave of absences (whether for vacation, sick leave or other reasons), reported injuries, promotions and demotions, performance evaluations, reports of health examinations, job applications, and wages paid and/or earnings given (including W-2 forms), and all other pertinent documents, including any and all medical, psychological, or testing records or memoranda. Yes ____ No ____

O. If your answer to Question L above is YES, for each of your employers identified in any of your responses to the questions above, please produce two executed copies of the release form Authorization for Release of Employment Records attached as Ex. G, permitting Merck to obtain your employment records, including W-2 forms.

P. Have you ever served in the military? Yes_____No_____

If your answer is YES, please produce an executed copy of Standard Form 180 attached as Ex. H, permitting Merck to obtain your military personnel, service, and health records.

Q. Copies of all documents from any healthcare provider (as defined above) or others discussing, describing, relating to, or memorializing your treatment with Fosamax or to any condition you claim is related to the use of Fosamax. Yes ____ No ____

R. For each insurance company or other organization that has insured you from twelve (12) years prior to your first use of Fosamax to the present, produce an executed copy of the authorization, attached as Ex. I, authorizing Merck to obtain all insurance records from each such company.

S. All documents constituting, concerning or relating to product use instructions,

product warnings, package inserts, handouts or other materials distributed with or provided to you in connection with your use of Fosamax.
Yes ____ No ____

T. Copies of advertisements, written or Internet materials or promotions for Fosamax which you saw prior to or during your use of the medication.
Yes ____ No ____

U. Copies of all websites you visited regarding Fosamax or any other bisphosphonates, your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges.
Yes ____ No ____

V. Copies of transcripts of Internet chat room discussions in which you participated regarding Fosamax, any other bisphosphonates, your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges. Yes ____ No ____

W. Copies of email relating to Fosamax, any other bisphosphonates, your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges. Yes ____ No ____

X. All documents relating to Fosamax or any alleged health risks or hazards related to these drugs in your possession at or before the time of the injury alleged in your Complaint. Yes ____ No ____

Y. All documents you (and not your lawyer) obtained directly or indirectly from Merck. Yes ____ No ____

Z. All diaries, calendars or any other writings or recordings made by you, or by any other person, describing, discussing, explaining or referring to the injuries, damages, or causes of action alleged by you in the Complaint, not including those items covered by the Attorney-Client or Work Product Privileges. Yes ____ No ____

AA. All diaries, calendars or any other writings or recordings made by you, or by any other person, describing, discussing, explaining or referring to the underlying illness or disease for which you received Fosamax, not including those items covered by the Attorney-Client or Work Product Privileges.
Yes ____ No ____

BB. Copies of all documents you (and not your attorneys) obtained from any source related to Fosamax or to the alleged effects of such medications, not including those items covered by the Attorney-Client or work Product Privileges.
Yes ____ No ____

CC. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.
Yes ____ No ____

DD. Decedent's death certificate (if applicable).
Yes ____ No ____ Not applicable ____

XII. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

Identify the following:

A. Your current family and/or primary care physician:

Name	Address	Specialty	Approximate Dates of Treatment

B. Identify each of your *other* primary care physicians for the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	Address	Specialty	Approximate Dates of Treatment

C. Each hospital, clinic, or healthcare facility where you have received inpatient treatment or been admitted as a patient during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	Address	Admission Dates	Reason for Admission

D. Each hospital, clinic, or healthcare facility where you have received outpatient treatment (including treatment in an emergency room) during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	Address	Treatment Dates	Reason for Treatment

E. Identify each health care provider who has ever seen or treated you for osteoporosis or the underlying illness for which you took Fosamax.

Name	Address	Specialty	Approximate Dates of Treatment

F. Each dentist, orthodontist, periodontist, oral and maxillofacial surgeons or other healthcare provider involved in providing dental care or treatment who you have ever seen or from whom you have ever received treatment.

Name	Address	Specialty	Approximate Dates of Treatment

G. Identify any other healthcare provider by whom you have been seen or from whom you have received treatment for any reason during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	Address	Specialty	Approximate Dates of Treatment

H. If you are claiming any psychological or emotional damages, identify each psychiatrist, psychologist, mental health counselor, therapist and/or social worker from whom you have received treatment or with whom you have consulted regarding your health during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	**Address**	**Specialty**	**Approximate Dates of Treatment**

I. Each pharmacy that has dispensed medication to you in the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

Name	**Address**

DECLARATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Profile Form is true and correct to the best of my knowledge, I have supplied all the documents requested in part XI of this Profile Form to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and I have supplied the authorizations attached to this declaration.

_____	_____	_____
Signature	Print Name	Date

CLAC; 324433.1

EXHIBIT A

In Re: Fosamax Litigation
Superior Court of New Jersey, Law Division, Atlantic County
Case No. 282

AUTHORIZATION FOR RELEASE OF MEDICAL AND/OR DENTAL RECORDS

In Compliance With the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Name: _____

Date of Birth: _____

Social Security Number: _____

I hereby authorize _____ to release all existing medical and/or dental, orthodontic, periodontic, oral surgery and/or related records (Medical and/or Dental records) regarding the above-named person's Medical and/or Dental care, treatment, physical condition, and/or Medical and/or Dental expenses to the law firm of **WALLER LANSDEN DORTCH & DAVIS, PLLC 511, Union Street, Suite 2700, Nashville, Tennessee 37219 (counsel for Merck & Co., Inc.), or its designated agent(s) ("Receiving Parties").** These records shall be used or disclosed solely in connection with the currently pending litigation involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's litigation concludes.

I understand that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This authorization includes Medical and/or Dental records, kept in either hardcopy or electronic form, and also includes, but is not limited to, bone marrow pressure testing, PET scans, bone mineral density testing, micro-CT scans, mechanical testing, FE modeling, testing related to changes in mineral content or quality, testing related to changes in bone density, thickness, or height, bone scan results, bone biopsy results, microbial culture testing, urinary N-telopeptide testing, serum bone-specific alkaline phosphatase testing, x-ray reports, CT scan reports, MRI scans, EEGs, EKGs, sonograms, arteriograms, discharge summaries, photographs, surgery consent forms, admission and discharge records, operation records, doctor and nurses notes, referral forms, prescriptions, medical bills, dental bills, invoices, histories, diagnoses, narratives, and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments,

Medical and/or Dental records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc.). This listing is not meant to be exclusive.

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned, or discovered at any time in the future until the conclusion of the litigation, either by you or another party, you must produce such information to the Receiving Parties at that time. I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation.

Any photostatic copy of this document shall have the same authority as the original, and may be substantiated in its place. Copies of these materials are to be provided at the expense of Waller Lansden Dortch & Davis, PLLC, counsel for Merck & Co., Inc. Copies of any records obtained will be provided, per agreement, to my legal counsel.

Date: _____

_____

[*PLAINTIFF OR REPRESENTATIVE]*

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:

_____

_____

_____

_____

EXHIBIT B

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Waller Lansden Dortch & Davis Attn: Lela Hollabaugh
511 Union Street, Suite 2700 Nashville, Tennessee 37219

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☒ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☒ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☒ COPY OF HOSPITAL SUMMARY ☒ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

All medical records, specifically including, but not limited to: medical history or examination reports, films, prescription records, and dental treatment.

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

For purposes of personal injury litigation.

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

EXHIBIT C

_____
Full Name

_____
Social Security Number

_____
Date of Birth

In Re: Fosamax Litigation
Superior Court of New Jersey, Law Division, Atlantic County
Case No. 282

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORDS

In Compliance With the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

To:

_____
Name of Entity

_____
Address

_____
City, State, Zip Code

You are hereby authorized to release my entire medical records file to the Records Requester(s) listed below. This release authorizes you to furnish copies of any information, including but not limited to the medical records, psychotherapy notes, and clinical information concerning the assessment, evaluation, treatment, and/or hospitalization related to mental health or psychiatric illnesses or conditions.

This authorization is being given at my request in conjunction with the civil litigation matter listed above. You are hereby authorized to release these medical records to the following Records Requester(s) for their use in the above-entitled litigation. The defendant has agreed to pay reasonable charges to supply copies of such records. Copies of any records obtained will be provided, per agreement, to my legal counsel. You should provide all documents and information to:

Records Requester(s)

1. Waller Lansden Dortch & Davis, 511 Union Street, Suite 2700 Nashville, Tennessee, 37219 (counsel for Merck & Co., Inc.), or their designated agent(s) ("Receiving Party").

I understand that the health information being disclosed by these psychotherapy notes may include information relating to and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted diseases and drug and alcohol disorders.

I understand that this authorization pertains to the civil litigation referenced above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other final judicial order, including but not limited to the resolution of any and all appeals. I understand that this authorization remains in full force and effect until such expiration or revocation, as more fully described below, and further authorizes you to release to the Records Requester(s) any additional records created or obtained by you after the date of execution of this authorization. I understand and intend that you may rely on this authorization in all respects unless you have previously been advised by me in writing to the contrary.

I understand that I may revoke this authorization at any time by providing you a written revocation, but that my revocation will be effective only to the extent that the information has not already been released. I further understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign this authorization.

It is expressly understood and intended by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

I understand that any documents or information released by you could potentially be re-disclosed by the aforementioned Records Requester(s) and that any information re-disclosed by that party is not subject to this authorization and may not be subject to HIPAA, the Federal Regulations promulgated under the authority of HIPAA, and more specifically, the requirements imposed by 45 C.F.R. § 164.508. I expressly permit the Records Requester(s) to re-disclose my medical records file for purposes limited to this civil litigation matter or related to the defendant's legal obligations to provide information to the Food and Drug Administration.

This authorization shall not be valid unless the Records Requester(s) named above has executed the acknowledgment at the bottom of this authorization.

This authorization is executed and served in compliance with HIPAA, the Federal Regulations promulgated thereunder, and more specifically, 45 C.F.R. § 164.508, all of which govern the requirements for the release of private health information.

Name of Patient	Signature	Date of Birth	Date Signed

Description of Legal Guardian/Personal Representative's authority to act for Patient.

Subscribed and sworn to before me this ____ day of _____, 200_.

_____
Notary Public

My Commission Expires:

_____

ACKNOWLEDGMENT

The undersigned, as the Records Requester(s) named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the patient named in the foregoing medical authorization has been given notice that the authorization will be used to request records and information from the person or entity to whom it is addressed. The attorney for or the person named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records requested from the undersigned requester at a reasonable cost.

Records Requester's Signature: [signature]
partner, Waller Lansden Dortch & Davis, LLP

EXHIBIT D

Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

Please read these instructions carefully before completing this form.

When to Use This Form

Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor, or an insurance company).

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:

- **nonmedical** records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F4. You can get this form at any Social Security office.

How to Complete This Form

This consent form must be completed and signed only by:

- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the **nonmedical** information applies, or
- the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

PAPERWORK REDUCTION ACT: Paperwork Reduction Act Statement: This information collection meets the clearance requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. The office is listed under U. S. Government agencies in your telephone directory or you may call 1-800-772-1213 for the address. You may send comments on our estimate of the time needed to complete the form to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

Form Approved
OMB No. 0960-0566

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
Venable LLP	Attn: Christina Gaarder
750 E. Pratt St., Suite 900	Baltimore, MD 21202

I want this information released because:
For purposes of personal injury litigation.

(There may be a charge for releasing information.)

Please release the following information:

x Social Security Number
x Identifying information (includes date and place of birth, parents' names)
x Monthly Social Security benefit amount
x Monthly Supplemental Security Income payment amount
___ Information about benefits/payments I received from ___ to ___
___ Information about my Medicare claim/coverage from ___ to ___
(specify) ___
x Medical records
x Record(s) from my file (specify) Records pertaining to my claims for disability benefits, such as my requests for disability benefits or administrative hearing records and determination based upon any applications for disability benefits.
___ Other (specify) ___

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: ___
(Show signatures, names, and addresses of two people if signed by mark.)
Date: ___ Relationship: ___

Form SSA-3288 (3-2005) EF (3-2005)

_____
Full Name

_____
Social Security Number

_____
Date of Birth

In Re: Fosamax Litigation
Superior Court of New Jersey, Law Division, Atlantic County
Case No. 282

AUTHORIZATION FOR RELEASE OF DISABILITY INSURANCE RECORDS

To:

_____
Name of Disability Insurance Carrier

_____
Address

_____
City, State, Zip Code

I hereby authorize the law firm of VENABLE LLP, 750 E. Pratt Street, Suite 900, Baltimore, Maryland 21202 (counsel for Merck & Co., Inc.), or their designated agent(s) ("Receiving Parties"), to be furnished copies of my entire insurance file, including but not limited to any and all health insurance questionnaires, claims made by or against me, and any documents discussing, describing, or explaining the investigation and processing of that claim and all other pertinent documents, including all medical records or memoranda. The defendant has agreed to pay reasonable charges to supply copies of such records.

This authorization is being given at my request in conjunction with the civil litigation matter listed above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other final judicial order, including but not limited to the resolution of any and all appeals. Until then, this authorization shall be considered as continuing, and you may rely on it in all respects unless and until you have been advised by me in writing to the contrary. Please note that this authorization also permits you to release any records created or obtained by you after the date of execution of this authorization.

It is expressly understood and not intended by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Name of Patient	Signature	Date of Birth	Date Signed

Description of Legal Guardian/Personal Representative's authority to act for Patient.

Subscribed and sworn to before me this ____ day of _____, 200_.

_____
Notary Public

My Commission Expires:

_____

BA2/357429

_____
Full Name

_____
Social Security Number

_____
Date of Birth

In Re: Fosamax Litigation
Superior Court of New Jersey, Law Division, Atlantic County
Case No. 282

AUTHORIZATION FOR RELEASE OF WORKERS' COMPENSATION RECORDS

To:

_____
Name of Entity

_____
Address

_____
City, State, Zip Code

I hereby authorize the law firm of VENABLE LLP, 750 E. Pratt Street, Suite 900, Baltimore, Maryland 21202 (counsel for Merck & Co., Inc.), or their designated agent(s) ("Receiving Party"), to be furnished copies of my entire workers' compensation file, including but not limited to any claims made by me, and any documents discussing, describing, or explaining the investigation and processing of that claim and all other pertinent documents, including all medical records or memoranda. The defendant has agreed to pay reasonable charges to supply copies of such records.

This authorization is being given at my request in conjunction with the civil litigation matter listed above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other final judicial order, including but not limited to the resolution of any and all appeals. Until then, this authorization shall be considered as continuing, and you may rely on it in all respects unless and until you have been advised by me in writing to the contrary. Please note that this authorization also permits you to release any records created or obtained by you after the date of execution of this authorization.

It is expressly understood and not intended by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Name	Signature	Date of Birth	Date Signed

Description of Legal Guardian/Personal Representative's authority to act for Patient

Subscribed and sworn to before me this ____ day of _____, 200_.

_____
Notary Public

My Commission Expires:

Ba2/357429

EXHIBIT E

Form **4506**

(Rev. April 2006)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ Do not sign this form unless all applicable lines have been completed. Read the instructions on page 2.

▶ Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.

OMB No. 1545-0429

Tip: You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the tax return and usually contains the information that a third party (such as a mortgage company) requires. See Form 4506-T, Request for Transcript of Tax Return, or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return	2b Second social security number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.

Venable,LLP, 750 E. Pratt Street, Suite 900, Baltimore, MD 21202
Attn: Christina Gaarder; Phone: 410-244-7400; Fax: 410-244-7742

Caution: *If a third party requires you to complete Form 4506, do not sign Form 4506 if lines 6 and 7 are blank.*

6 **Tax return requested** (Form 1040, 1120, 941, etc.) and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ 1040 and all attachments
Note. *If the copies must be certified for court or administrative proceedings, check here.* ☑

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

/ /	/ /	/ /	/ /
/ /	/ /	/ /	/ /

8 **Fee.** There is a $39 fee for each return requested. Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.

a Cost for each return	$ 39.00
b Number of returns requested on line 7	
c Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here ☑

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, either husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer.

Telephone number of taxpayer on line 1a or 2a ( )

Sign Here

▶ Signature (see instructions) — Date

▶ Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ Spouse's signature — Date

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 41721E Form **4506** (Rev. 4-2006)

General Instructions

Section references are to the Internal Revenue Code.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate a third party to receive the tax return. See line 5.

How long will it take? It may take up to 60 calendar days for us to process your request.

Tip. Use Form 4506-T, Request for Transcript of Tax Return, to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of non-filing, and record of account.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

Note. *If you are requesting a return for more than one year and the chart below shows two different service centers, mail your request to the service center based on the address of your most recent return.*

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to the "Internal Revenue Service" at:
District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New York, Vermont	RAIVS Team Stop 679 Andover, MA 05501
Alabama, Delaware, Florida, Georgia, North Carolina, Rhode Island, South Carolina, Virginia	RAIVS Team P.O. Box 47-421 Stop 91 Doraville, GA 30362
Arkansas, Kansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee, Texas, West Virginia	RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nebraska, Nevada, New Mexico, Oregon, South Dakota, Utah, Washington, Wyoming	RAIVS Team Stop 38101 Fresno, CA 93888
Connecticut, Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, North Dakota, Ohio, Wisconsin	RAIVS Team Stop 6705-B41 Kansas City, MO 64999
New Jersey, Pennsylvania, a foreign country, or A.P.O. or F.P.O. address	RAIVS Team DP 135SE Philadelphia, PA 19255-0695

Chart for all other returns

If you lived in or your business was in:	Mail to the "Internal Revenue Service" at:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Utah, Washington, Wyoming	RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409
Connecticut, Delaware, District of Columbia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia, Wisconsin	RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250
A foreign country, or A.P.O. or F.P.O. address	RAIVS Team DP 135SE Philadelphia, PA 19255-0695

Specific Instructions

Line 1b. Enter your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the return be sent to a third party, the IRS must receive Form 4506 within 60 days of the date signed by the taxpayer or it will be rejected.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the Letters Testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. Sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, and the District of Columbia for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6406, Washington, DC 20224. Do not send the form to this address. Instead, see *Where to file* on this page.

_____
Full Name

_____
Social Security Number

_____
Date of Birth

In Re: Fosamax Litigation
Superior Court of New Jersey, Law Division, Atlantic County
Case No. 282

AUTHORIZATION FOR RELEASE OF DEPARTMENT OF REVENUE RECORDS

To:

_____
Name of Entity

_____
Address

_____
City, State, Zip Code

I hereby authorize the law firm of VENABLE LLP, 750 E. Pratt Street, Suite 900, Baltimore, Maryland 21202 (counsel for Merck & Co., Inc.), or their designated agent(s) ("Receiving Party"), to be furnished copies of the previously filed income tax returns filed by _____. The defendant has agreed to pay reasonable charges to supply copies of such records.

This authorization is being given at my request in conjunction with the civil litigation matter listed above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other final judicial order, including but not limited to the resolution of any and all appeals. Until then, this authorization shall be considered as continuing, and you may rely on it in all respects unless and until you have been advised by me in writing to the contrary. Please note that this authorization also permits you to release any records created or obtained by you after the date of execution of this authorization.

It is expressly understood and not intended by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Name	Signature	Date of Birth	Date Signed

Description of Legal Guardian/Personal Representative's authority to act for Patient

Subscribed and sworn to before me this ____ day of _____, 200_.

_____
Notary Public

My Commission Expires:

BA2/357429

EXHIBIT F

Form Approved
OMB No. 0960-0525

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. **Certified/Non-Certified Detailed Earnings Information**

   Includes periods of employment or self-employment and the names and addresses of employers.

   OR

2. **Certified Yearly Totals of Earnings**

   Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM FOR:

Non-certified yearly totals of earnings

This service is free to the public.

These totals can be obtained by calling 1-800-772-1213 to receive Form SSA-7004, Request for Earnings and Benefit Estimate Statement.

PRIVACY ACT NOTICE: We are authorized to collect this information under section 205 of the Social Security Act, and the Federal Records Act of 1950 (64 Stat. 583). It is needed so we can identify your records and prepare the statement you request. You do not have to furnish the information, but failure to do so may prevent your request from being processed.

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 11 minutes to read the instructions, gather the necessary facts, and answer the questions.

INFORMATION ABOUT YOUR REQUEST

- **How Do I Get This Information?**

  You need to complete the attached form to tell us what information you want.

- **Can I Get This Information For Someone Else?**

  Yes, if you have their written permission. For more information, see page 3.

- **Who Can Sign On Behalf Of The Individual?**

  The parent of a minor child, or the legal guardian of an individual who has been declared legally incompetent, may sign if he/she is acting on behalf of the individual.

- **Is There A Fee For This Information?**

  1. **Certified/Non-Certified Detailed Earnings Information**

     Yes, we usually charge a fee for detailed information. In most cases, this information is used for purposes NOT directly related to Social Security such as for a private pension plan or personal injury suit. The fee chart on page 3 gives the amount of the charge.

     Sometimes, there is no charge for detailed information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the period in question. Occasionally, earnings amounts are wrong because an employer did not correctly report earnings or earnings are credited to the wrong person. In situations like these, we will send you detailed information, at no charge, so we can correct your record.

     Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

     We will certify the detailed earnings information for an additional fee of $15.00. Certification is usually not necessary unless you plan to use the information in court.

  2. **Certified Yearly Total of Earnings**

     Yes, there is a fee of $15 to certify yearly totals of earnings. Cetification is usually not necessary unless you plan to use the information in court.

  3. **Method of Payment**

     Enclose a check or money order for the entire fee required. Payment can also be made by credit card. To do so, complete page 4 of this form and return it with your request form.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

   Print the Name, Social Security Number (SSN), and date of birth below.

   Name _____ Social Security Number _____

   Other Name(s) Used (Include Maiden Name) _____ Date of Birth (Mo/Day/Yr) _____

2. What kind of information do you need?

   [X] **Detailed Earnings Information** (If you check this block, tell us below why you need this information.) For the period(s)/year(s): _____

   For purposes of personal injury litigation.

   [X] **Certified Total Earnings For Each Year.** (Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Earnings and Benefit Estimate Statement) For the year(s): _____

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 . . . . . A. $ 80.00

   Do you want us to certify the information? [X] Yes [ ] No

   If yes, enter $15.00 . . . . . B. $ 15.00

   ADD the amounts on lines A and B, and enter the TOTAL amount . . . . . C. $ 95.00

   - You can pay by CREDIT CARD by completing and returning the form on page 4, or
   - Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payble to "Social Security Administration"
   - DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

   SIGN your name here (Do not print) > _____ Date _____

   Daytime Phone Number _____ _____
   (Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

   Name Venable LLP, Attn: Christina Gaarder Address 750 E. Pratt Street, Suite 900

   City, State & Zip Code Baltimore, MD 21202

6. Mail Completed Form(s) To:

   Social Security Administration
   Division of Earnings Record Operations
   P.O. Box 33003
   Baltimore Maryland 21290-3003

   Exception: If using private contractor (e.g., FedEx) to mail form(s), use:

   Social Security Administration
   Division of Earnings Record Operations
   300 N. Greene St.
   Baltimore Maryland 21290-0300

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

How Much Do I Have to Pay For Detailed Earnings?

1. Count the number of years for which you need detailed earnings information. Be sure to add in both the first and last year requested. However, do not add in the current calendar year since this information is not yet available.

2. Use the chart below to determine the correct fee.

Number of Years Requested	Fee	Number of Years Requested	Fee	Number of Years Requested	Fee
1	$15.00	15	$43.75	28	$64.50
2	17.50	16	45.50	29	66.00
3	20.00	17	47.25	30	67.50
4	22.50	18	49.00	31	68.75
5	25.00	19	50.75	32	70.00
6	27.00	20	52.50	33	71.25
7	29.00	21	54.00	34	72.50
8	31.00	22	55.50	35	73.75
9	33.00	23	57.00	36	75.00
10	35.00	24	58.50	37	76.25
11	36.75	25	60.00	38	77.50
12	38.50	26	61.50	39	78.75
13	40.25	27	63.00	40	80.00
14	42.00				

For Requests Over 40 Years, Please Add 1 Dollar for Each Additional Year.

- **Whose Earnings Can Be Requested**

1. **Your Earnings**

   You can request earnings information from your own record by completing the attached form; we need your handwritten signature. If you sign with an "X", your mark must be witnessed by two disinterested persons who must sign their name and address.

2. **Someone Else's Earnings**

   You can request earnings information from the record of someone else if that person tells us in writing to give the information to you. This writing or "authorization" must be presented to us within 60 days of the date it was signed by that person.

3. **A Deceased Person's Earnings**

   You can request earnings information from the record of a deceased person if you are the legal representative of the estate, a survivor (that is, the spouse, parent, child, divorced spouse of divorced parent), or an individual with a material interest (example-financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

   Proof of death must be included with your request. Proof of appointment as representative or proof of your relationship to the deceased must also be included.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply. You may also pay by check or money order.

Please fill in all the information below and return this form along with your request to:

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33003
Baltimore Maryland 21290-3003

Exception:
If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore Maryland 21290-0300

Note: Please read Paperwork/Privacy Act Notice

CHECK ONE →	☐ Visa ☐ American ☐ MasterCard ☐ Discover ☐ Diners Card
Credit Card Holder's Name → (Enter the name from the credit card)	First Name, Middle Initial, Last Name
Credit Card Holder's Address →	Number & Street City, State, & Zip Code
Daytime Telephone Number →	Area Code Telephone Number
Credit Card Number →	-- -- --
Credit Card Expiration Date →	Month Year
Amount Charged →	
Credit Card Holder's Signature →	

DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization	
	Name	Date
	Remittance Control #	

PRIVACY ACT NOTICE

The Social Security Administration (SSA) has authority to collect the information requested on this form under section 205 of the Social Security Act. Giving us this information is voluntary. You do not have to do it. We will need this information only if you choose to make payment by credit card. You do not need to fill out this form if you choose another means of payment (for example, by check or money order).

If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and SSA's account. We may also provide this information to another person or government agency to comply with federal laws requiring the release of information from our records. You can find these and other routine uses of information provided to SSA listed in the Federal Register. If you want more information about this, you may call or write any Social Security Office.

EXHIBIT G

_____
Full Name

_____
Social Security Number

_____
Date of Birth

In Re: Fosamax Litigation
Superior Court of New Jersey, Law Division, Atlantic County
Case No. 282

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

To:

_____
Name of Entity/Name of Employer

_____
Address

_____
City, State, Zip Code

I hereby authorize the law firm of VENABLE LLP, 750 E. Pratt Street, Suite 900, Baltimore, Maryland 21202 (counsel for Merck & Co., Inc.), or their designated agent(s) ("Receiving Party"), to be furnished copies of my entire personnel file, including but not limited to documents relating to attendance, leave of absences (whether for vacation, sick leave or other reasons), reported injuries, promotions and demotions, performance evaluations, reports of health examinations, job applications, and wages paid and/or earnings given (including W-2 forms), and all other pertinent documents, including any and all medical, psychological, or testing records or memoranda. The defendant has agreed to pay reasonable charges to supply copies of such records.

This authorization is being given at my request in conjunction with the civil litigation matter listed above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other final judicial order, including but not limited to the resolution of any and all appeals. Until then, this authorization shall be considered as continuing, and you may rely on it in all respects unless and until you have been advised by me in writing to the contrary. Please note that this authorization also permits you to release any records created or obtained by you after the date of execution of this authorization.

It is expressly understood and intended by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Name of Employee	Signature	Date of Birth	Date Signed

Description of Legal Guardian/Personal Representative's authority to act for Patient.

Subscribed and sworn to before me this ____ day of _____, 200_.

_____
Notary Public

My Commission Expires:

_____

EXHIBIT H

INSTRUCTION AND INFORMATION SHEET FOR SF 180, REQUEST PERTAINING TO MILITARY RECORDS

1. Information needed to locate records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available." Include as much of the requested information as you can.

2. Restrictions on release of information. Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations and the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's legal guardian has access to almost any information contained in that member's own record. An authorization signature, of the service member or the member's legal guardian, is needed in Section III of the SF180. Others requesting information from military personnel/health records must have the release authorization in Section III of the SF 180 signed by the member or legal guardian, but if the appropriate signature cannot be obtained, only limited types of information can be provided. If the former member is deceased, surviving next of kin may, under certain circumstances, be entitled to greater access to a deceased veteran's records than a member of the public. The next of kin may be any of the following: unremarried surviving spouse, father, mother, son, daughter, sister, or brother. Employers and others needing proof of military service are expected to accept the information shown on documents issued by the military service departments at the time a service member is separated.

3. Where reply may be sent. The reply may be sent to the member or any other address designated by the member or other authorized requester.

4. Charges for service. There is no charge for most services provided to members or their surviving next of kin. A nominal fee is charged for certain types of service. In most instances service fees cannot be determined in advance. If your request involves a service fee, you will be notified as soon as that determination is made.

5. Health and personnel records. Health records of persons on active duty are generally kept at the local servicing clinic, and usually are available from the Department of Veterans Affairs a week or two after the last day of active duty. (See page 2 of SF180 for record locations/addresses.)

6. Records at the National Personnel Records Center. Note that it takes at least three months, and often up to seven, for the file to reach the National Personnel Records Center in St. Louis after the military obligation has ended (such as by discharge). If only a short time has passed, please send the inquiry to the address shown for active or current reserve members. Also, if the person has only been released from active duty but is still in a reserve status, the personnel record will stay at the location specified for reservists. A person can retain a reserve obligation for several years, even without attending meetings or receiving annual training. (See page 2 of SF180 for record locations/addresses.)

7. Definitions and abbreviations. DISCHARGED -- the individual has no current military status; HEALTH -- Records of physical examinations, dental treatment, and outpatient medical treatment received while in a duty status (does not include records of treatment while hospitalized); TDRL -- Temporary Disability Retired List.

8. Service completed before World War I. National Archives Trust Fund (NATF) forms must be used to request these records. Obtain the forms by e-mail from *inquire@nara.gov* or write to the Code 6 address on page 2 of the SF 180.

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e)(3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the facility servicing the service member's record may not have all of the information needed to locate it. The purpose of the information on this form is to assist the facility servicing the records (see the address list) in locating the correct military service record(s) or information to answer your inquiry. This form is then filed in the requested military service record as a record of disclosure. The form may also be disclosed to Department of Defense components, the Department of Veterans Affairs, the Department of Homeland Security (DHS, U.S. Coast Guard), or the National Archives and Records Administration when the original custodian of the military health and personnel records transfers all or part of those records to that agency. If the service member was a member of the National Guard, the form may also be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served.

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

Public burden reporting for this collection of information is estimated to be five minutes per response, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (NHP), 8601 Adelphi Road, College Park, MD 20740-6001. DO NOT SEND COMPLETED FORMS TO THIS ADDRESS. SEND COMPLETED FORMS AS INDICATED IN THE ADDRESS LIST ON PAGE 2 OF THE SF 180.

Standard Form 180 (Rev. 10-85) (Page 1)
Prescribed by NARA (36 CFR 1228.160(b))

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Previous edition unusable

OMB No. 3095-0029 Expires 9/30/2008

REQUEST PERTAINING TO MILITARY RECORDS

To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type. If you need more space, use plain paper.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much as possible.)

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)

	BRANCH OF SERVICE	DATES OF SERVICE: DATE ENTERED	DATES OF SERVICE: DATE RELEASED	CHECK ONE: OFFICER	CHECK ONE: ENLISTED	SERVICE NUMBER DURING THIS PERIOD (If unknown, write "unknown")
a. ACTIVE SERVICE						
b. RESERVE SERVICE						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
☐ NO ☐ YES _____

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. **REPORT OF SEPARATION** (DD Form 214 or equivalent). This contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. NOTE: If more than one period of service was performed, even in the same branch, there may be more than one Report of Separation. Be sure to show EACH year that a Report of Separation was issued, for which you need a copy.

☒ An **UNDELETED** Report of Separation is requested for the year(s) _____

This normally will be a copy of the full separation document including such sensitive items as the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost. An undeleted version is ordinarily required to determine eligibility for benefits.

☐ A **DELETED** Report of Separation is requested for the year(s) _____

The following information will be deleted from the copy sent: authority for separation, reason for separation, reenlistment eligibility code, separation(SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

2. **OTHER INFORMATION AND/OR DOCUMENTS REQUESTED** All health and personall records.

3. **PURPOSE** (Optional – An explanation of the purpose of the request is strictly voluntary. Such information may help the agency answering this request to provide the best possible response and will in no way be used to make a decision to deny the request.)

Personal injury litigation.

SECTION III - RETURN ADDRESS AND SIGNATURE

1. **REQUESTER IS:**

☐ Military service member or veteran identified in Section I, above
☐ Next of kin of deceased veteran _____ (relation)
☐ Legal guardian (must submit copy of court appointment)
☐ Other (specify) _____

2. **SEND INFORMATION/DOCUMENTS TO:**
(Please print or type. See item 3 on accompanying instructions.)

Venable LLP, Attn: Christina Gaarder
Name

750 E. Pratt.Street, Suite 900
Street Apt.

Baltimore, Maryland 21202
City State Zip Code

3. **AUTHORIZATION SIGNATURE REQUIRED** *(See item 2 on accompanying instructions.)* I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct.

Signature (Please do not print.)

Date of this request ( ) Daytime phone

Email address

** This form is available at *http://www.archives.gov/research/order/standard-form-180.pdf* on the National Archives and Records Administration (NARA) web site.**

LOCATION OF MILITARY RECORDS

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	ADDRESS CODE	
		Personnel Record	Health Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired on or after 10/1/2004	1	11
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, retired reserve in nonpay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	13	
COAST GUARD	Discharge , deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired on or after 4/1/1998	14	11
	Active, reserve, or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1905	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired on or after 1/1/1999	4	11
	Individual Ready Reserve or Fleet Marine Corps Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	14
	Discharged, deceased, or retired 10/16/1992 – 9/30/2002	14	11
	Discharged, deceased, or retired on or after 10/1/2002	7	11
	Reserve; or active duty records of current National Guard members who performed service in the U.S. Army before 7/1/1972	7	
	Active enlisted (including National Guard on active duty in the U.S. Army) or TDRL enlisted	9	
	Active officers (including National Guard on active duty in the U.S. Army) or TDRL officers	8	
	Current National Guard enlisted not on active duty in Army (including records of Army active duty performed after 6/30/1972)	13	
	Current National Guard officers not on active duty in Army (including records of Army active duty performed after 6/30/1972)	12	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired on or after 1/1/1995	10	11
	Active, reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	15	

ADDRESS LIST OF CUSTODIANS (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1	Air Force Personnel Center HQ AFPC/DPSRP 550 C Street West, Suite 19 Randolph AFB, TX 78150-4721	6	National Archives & Records Administration Old Military and Civil Records (NWCTB-Military) Textual Services Division 700 Pennsylvania Ave., N.W. Washington, DC 20408-0001	11	Department of Veterans Affairs Records Management Center P.O. Box 5020 St. Louis, MO 63115-5020
2	Air Reserve Personnel Center /DSMR HQ ARPC/DPSSA/B 6760 E. Irvington Place, Suite 4600 Denver, CO 80280-4600	7	U.S. Army Human Resources Command ATTN: AHRC-PAV-V 1 Reserve Way St. Louis, MO 63132-5200	12	Army National Guard Readiness Center NGB-ARP 111 S. George Mason Dr. Arlington, VA 22204-1382
3	Commander, CGPC-adm-3 USCG Personnel Command 4200 Wilson Blvd., Suite 1100 Arlington, VA 22203-1804	8	U.S. Army Human Resources Command ATTN: AHRC-MSR 200 Stovall Street Alexandria, VA 22332-0444	13	The Adjutant General (of the appropriate state, DC, or Puerto Rico)
4	Headquarters U.S. Marine Corps Personnel Management Support Branch (MMSB-10) 2008 Elliot Road Quantico, VA 22134-5030	9	Commander USAEREC ATTN: PCRE-F 8899 E. 56th St. Indianapolis, IN 46249-5301	14	National Personnel Records Center (Military Personnel Records) 9700 Page Ave. St. Louis, MO 63132-5100
5	Marine Corps Reserve Support Command (Code MMI) 15303 Andrews Road Kansas City, MO 64147-1207	10	Navy Personnel Command (PERS-313C1) 5720 Integrity Drive Millington, TN 38055-3130	15	Division of Commissioned Corps Officer Support ATTN: Records Officer 1101 Wootton Parkway, Plaza Level, Suite 100 Rockville, MD 20852

EXHIBIT I

_____
Full Name

_____
Social Security Number

_____
Date of Birth

In Re: Fosamax Litigation
Superior Court of New Jersey, Law Division, Atlantic County
Case No. 282

AUTHORIZATION FOR RELEASE OF HEALTH INSURANCE RECORDS

To:

_____
Name of Health Insurance Carrier

_____
Address

_____
City, State, Zip Code

I hereby authorize the law firm of VENABLE LLP, 750 E. Pratt Street, Suite 900, Baltimore, Maryland 21202 (counsel for Merck & Co., Inc.), or their designated agent(s) ("Receiving Parties"), to be furnished copies of my entire insurance file, including but not limited to any and all health insurance questionnaires, claims made by or against me, and any documents discussing, describing, or explaining the investigation and processing of that claim and all other pertinent documents, including all medical records or memoranda. The defendant has agreed to pay reasonable charges to supply copies of such records.

This authorization is being given at my request in conjunction with the civil litigation matter listed above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other final judicial order, including but not limited to the resolution of any and all appeals. Until then, this authorization shall be considered as continuing, and you may rely on it in all respects unless and until you have been advised by me in writing to the contrary. Please note that this authorization also permits you to release any records created or obtained by you after the date of execution of this authorization.

It is expressly understood and not intended by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Name	Signature	Date of Birth	Date Signed

Description of Legal Guardian/Personal Representative's authority to act for Patient

Subscribed and sworn to before me this ____ day of _____, 200_.

_____
Notary Public

My Commission Expires:

TO1/269826

Exhibit 2

IN RE: FOSAMAX LITIGATION	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: ATLANTIC COUNTY CASE NO. 282 CIVIL ACTION
[INSERT INDIVIDUAL CASE CAPTION]	

DEFENDANT MERCK CASE PROFILE FORM

For each case, Defendant Merck must complete this Case Profile Form. This Case Profile Form must be completed and served on all counsel in the action identified in Section I below. This must be answered and served 60 days after the date that the Plaintiff's Profile Form, complete in all material respects, has been served on Defendant Merck & Co.

You should attach additional sheets of paper if that is necessary to completely answer the following questions.

I. CASE INFORMATION

This defendant fact sheet pertains to the following case:

Case caption:_____

Civil Action No._____

II. CONTACTS WITH PRESCRIBING HEALTH CARE PROVIDER

In Section _____ of Plaintiff's Profile Form, plaintiff identified persons or entities who prescribed or dispensed Fosamax or Fosamax Plus D to plaintiff (hereinafter "Prescribing Health Care Provider"). For each Prescribing Health Care Provider identified, please state and, where requested, provide the following:

A. Dear Doctor or Dear Healthcare Provider Letters:

1. For each "Dear Doctor" or "Dear Healthcare Provider" letter that you contend was *actually sent* to plaintiff's Prescribing Health Care Provider, please: a.) identify the letter sent; b.) state the date that each letter was actually sent to plaintiff's Prescribing Health Care Provider; c.) state the person to whom each letter was actually sent, d.) state the address where it was sent, e.) identify the

database or documents that demonstrate these facts and, f.) identify the persons who provided information responsive to this request.

NOTE: Please attach hereto a copy of each letter allegedly sent to plaintiff's Prescribing Health Care Provider.

2. In addition, Merck will identify any Professional Information Request letters concerning Fosamax or Fosamax Plus D that Merck contends or believes were actually sent to the Plaintiff's Prescribing Health Care Provider identified in Section ____ of the Plaintiff's Profile Form within the relevant time period set forth above. Merck will also identify (a) the date that each letter was sent to Plaintiff's Prescribing Health Care Provider; and (b) the address where each letter was sent.

B. Other Contacts

1. For each Prescribing Health Care Provider identified, please identify all contacts between Merck sales representatives and that provider concerning Fosamax or Fosamax Plus D and please produce the following information:

Plaintiff's Prescribing Health Care Provider	**The current relationship, if any, between Merck and the sales representative**	**Identity and last known address and telephone number for former Merck representative**	**Date(s) of Contact**

2. For each Prescribing Health Care Provider, please state whether Merck or its representatives ever provided him or her Fosamax or Fosamax Plus D samples. If the answer is "yes," please state:

a) The number of sample packets provided and the dosages provided;

b) The dates that they were shipped and/or provided;

c) The lot numbers for the samples provided on each date identified;

d) The identity of the person or persons who provided the samples.

C. Consulting With Plaintiff's Prescribing Health Care Provider

1 In Section _____ of Plaintiff's Profile Form, plaintiff identified his/her Prescribing Health Care Provider(s). If you have ever retained any of plaintiff's Prescribing Health Care Providers as a "thought leader" or "advocate", a member of Merck's Speaker Program, a Merck Clinical Investigator, or a consultant in any other capacity on the subject of osteoporosis medications, please state:

a) The identity of the Prescribing Health Care Provider consultant:

_____.

b) The dates they were affiliated with Merck:

_____

c) The amount of money Merck paid in expenses, honoraria and fees, per calendar year.

_____

d) Please identify or produce all consulting agreements and contracts.

_____

2. For each of plaintiff's Prescribing Health Care Providers identified in section II.C.1 (a) above, please state whether they were ever invited to attend and/or did in fact attend any Merck sponsored conferences or events. If your answer is "yes," please state:

a) The identity of the Prescribing Health Care Provider attendee:

_____.

b) The title, location and date of the speaker's program attended:

_____

c) The topic of the speaker's program:

_____

3. Has plaintiff's Prescribing Health Care Provider ever contacted you to request information concerning Fosamax or Fosamax Plus D, its indications, its effects and/or its risks?

_____ Yes _____ No

If your answer is "yes," please identify and attach any document which refers to your communication with plaintiff's Prescribing Health Care Provider.

_____

III. PLAINTIFF'S PRESCRIBING HEALTH CARE PROVIDER'S PRESCRIBING PRACTICES

In Section ____ of Plaintiff's Profile Form, plaintiff identified his/her Prescribing Health Care Provider(s). For each listed provider, please state and produce the following:

1. Do you have or have you had access to any database or information which purports to track any of plaintiff's Prescribing Health Care Provider's prescribing practices with respect to Fosamax, Fosamax Plus D, or any other osteoporosis medication (including, but not limited to the product(s) prescribed, the number or prescriptions, the number of refills and the time frame when these products were prescribed or (re) filled)?

_____ Yes _____ No

If your answer is "yes," please produce or identify the database or

document which captures that information.

IV. PLAINTIFF'S MEDICAL CONDITION

1. Have you been contacted by Plaintiff, any of his/her physicians, or anyone on behalf of plaintiff concerning plaintiff?

   _____ Yes _____ No

   If your answer is "yes", please a) state the name of the person(s) who contacted you, b) state the person(s) who were contacted including their name, address and telephone number and, c) produce or identify any and all documents which reflect any communication between any person and you concerning plaintiff.

2. Please produce a copy of any MedWatch form which refers or relates to plaintiff, including back-up documentation concerning plaintiff and any evaluation you did concerning the plaintiff.

V. DOCUMENTS

To the extent you have not already done so, please produce a copy of the following documents. These include documents in your possession, including information provided to your attorneys:

1. Any document which relates to or refers to plaintiff.

2. Any document sent to or received from any of plaintiff's prescribing physicians.

3. Any document reflecting any actual communication between you and plaintiff's prescribing physician's concerning the risks associated with Fosamax or Fosamax Plus D.

4. Any document which purports to describe the prescribing practices of any of plaintiff's prescribing physicians.

CERTIFICATION

I declare under penalty of perjury that all of the information provided in this Case Profile Form is true and correct to the best of my knowledge and that I have supplied all requested documents to the extent that such documents are in my possession, custody and control (including the custody and control of my lawyers).

_____	_____	_____
Signature	Print name	Date