
IN RE YAZ®, YASMIN®, OCELLA®
LITIGATION

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: BERGEN COUNTY

CASE NO. 287

CIVIL ACTION

FILED

JUL 22 2010

BRIAN R. MARTINOTTI, J.S.C.

This Document Relates to All Actions

CASE MANAGEMENT ORDER NO. 7

PLAINTIFF FACT SHEET

This matter, having been opened to the Court by counsel for the Parties, and the Parties having consented, stipulated and agreed to the entry of this Case Management Order, and good cause appearing therefore;

IT IS, on this 22 day of July, 2010, hereby **ORDERED** as follows:

A. Plaintiff Fact Sheet, Authorizations and Responsive Documents.

1. The parties¹ have agreed upon a Plaintiff Fact Sheet (“PFS”) that includes document requests in Section XII and a variety of Authorizations. *See* Exhibit 1. Each Plaintiff shall produce to Defendants a completed PFS, executed Authorizations and documents responsive to Section XII of the PFS (“Responsive Documents”) pursuant to the terms of this Order.

2. A completed PFS, which requires that each Plaintiff sign the Declaration in Section XIII, shall be considered to be interrogatory answers and responses to requests for production under the Rules Governing the Court of the State of New Jersey, and will be governed by the standards applicable to written discovery under the Rules Governing the Court

¹ In the event that any future case alleging injury from ingestion of Gianvi is determined to be appropriate for inclusion in this coordinated proceeding, this Case Management Order will apply to the Pharmaceutical Company Defendants named and properly served in that case.

of the State of New Jersey. Accordingly, Defendants' use of the PFS is in lieu of interrogatories and other discovery devices that they would otherwise have propounded. As set forth below in Section C, each PFS that is completed must be substantially complete. The PFS questions and requests for production have been negotiated and agreed to by the parties. All objections to the admissibility of information contained in the PFS are reserved and therefore no objections shall be lodged in the response to the questions and requests contained in the PFS.

3. Nothing in this section prohibits a Plaintiff from withholding or redacting information based upon a recognized privilege. If information is withheld or redacted on the basis of privilege, Plaintiff shall provide Defendants with a privilege log. In the event that a dispute arises concerning the completeness or adequacy of a Plaintiff's response to any request contained in the PFS, this section shall not prohibit the Plaintiff from asserting that his or her response is adequate.

4. Nothing in the PFS shall be deemed to limit the scope of inquiry at depositions and admissibility of evidence at trial. The scope of inquiry at depositions shall remain governed by the Rules Governing the Court of the State of New Jersey. The admissibility of information in responses to the PFS shall be governed by the Rules Governing the Court of the State of New Jersey and no objections are waived by virtue of any PFS response.

B. Schedule of Production of PFSs.

1. Each Plaintiff whose case is docketed in this mass tort proceeding as of the date of entry of this Order shall have 45 days from the date of this Order to produce to Defendants a completed PFS, executed Authorizations and Responsive Documents. Each Plaintiff whose case is docketed in this mass tort proceeding after the date of entry of this Order shall have 45 days

from the date that service of her Complaint is made on the first Defendant to produce to Defendants a completed PFS, executed Authorizations and Responsive Documents.

2. Plaintiffs who file a case directly in the Superior Court of Bergen County are hereby on notice that, pursuant to this Order, each Plaintiff has 45 days from the date of service of the first answer to her Complaint to produce to Defendants a completed PFS, executed Authorizations and Responsive Documents.

3. Service of the PFS shall be either in hard-copy or in an electronic format on CD via first class mail, addressed to Defendants' Counsel at:

YAZ®/Yasmin®/Ocella® Plaintiff Fact Sheet c/o Jennifer La Mont, Esq. Drinker Biddle & Reath LLP 500 Campus Drive Florham Park, New Jersey 07932-1047
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C. **PFSs Must Be Substantially Complete in All Respects.** Every Plaintiff is required to provide Defendants' Counsel (as set forth above) with a PFS that is substantially complete in all respects. Substantially complete in all respects requires a Plaintiff to:

1. Answer all applicable questions in the PFS (Plaintiff may answer questions in good faith by indicating "not applicable" or "I don't know" or "Unknown");
2. Include a signed Declaration (found at Section XIII of the PFS);
3. Provide duly executed record release Authorizations; and
4. Produce the documents requested in the PFS, to the extent such documents are in Plaintiff's possession.

D. Authorizations for the Release of Records.

1. As set forth above, Authorizations for the Release of Records together with copies of such records, to the extent that those records or copies thereof are in the Plaintiff's possession, shall be provided, completed in full but for the date, along with the PFS at the time that the Plaintiff is required to serve a PFS pursuant to this Order.

2. In addition to the addressed Authorizations described above, Plaintiff's counsel shall also maintain in their file unaddressed, executed Authorizations. Plaintiff's counsel shall provide executed Authorizations to Defendants' counsel within 21 days of a request for Authorizations.

3. Undated Authorizations constitute permission for Defendants to date (and where applicable, re-date) Authorizations before sending to records custodians. Should Plaintiffs provide Authorizations that are undated, this shall not constitute a deficiency or be deemed a substantially non-complete PFS.

4. With respect to Authorizations provided to Defendants that are dated, Defendants and their record copy vendor, Litigation Management, Inc. ("LMI") are hereby authorized to re-date the Authorizations to the date that they are being sent to the Healthcare Providers and other entities that require Authorizations, provided that the date affixed is not later than December 31, 2011. Defendants and LMI shall be permitted to "white out" the date and re-date.

5. In the event that a signed Authorization does not contain the following information with respect to the Plaintiff – or, in the case of an Authorization signed in a representative capacity, the information with respect to the represented party – Defendants and LMI are authorized to fill in the following information:

a. The name and/or address of the Plaintiff, or represented party, at the top of the Authorization;

b. The social security number of the Plaintiff or represented party;

c. The date of birth of the Plaintiff or represented party;

d. The name of defense counsel or LMI as the party to whom records may be released.

6. With respect to Authorizations signed "in blank" (i.e., without setting forth the identity of the custodian of records or provider of care), Defendants and LMI may address such Authorizations and use such Authorizations to obtain records for only those Healthcare Providers and other sources of records (e.g., pharmacies, employers, etc.) identified in the PFS, subject to the limitations for Educational and Employment Authorizations, as identified in Sections XII.A.3 and XII.A.6 of the PFS. Defendants or LMI shall provide e-mail notice to Plaintiff's counsel when an Authorization is changed consistent with this paragraph three (3) business days prior to sending the Authorization to a provider.

7. In the event that an institution or medical provider to whom any Authorization is presented refuses to provide records in response to that Authorization, Defendants shall notify Plaintiff's individual representative counsel. Should a particular form be required, Defendants will provide it to Plaintiff's individual representative counsel. The individual Plaintiff shall execute and return within 21 days whatever form is required by that institution or provider.

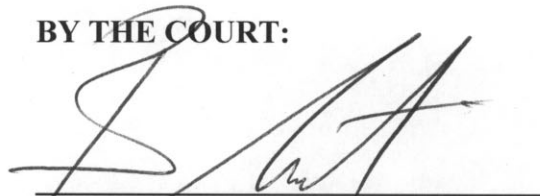
8. Defendants' record copy service vendor shall have the right to contact institutions or medical providers to follow-up on medical record copying or production.

E. Non-compliance with PFS Requirements. Any Plaintiff who fails to comply with her PFS obligations under this Order may be subject to having her claims, as well as any derivative

claim(s), dismissed. If Defendants have not received a completed PFS from a Plaintiff within 20 days following the due date set forth herein, Defendants will send a Notice of Overdue Discovery to Plaintiff's counsel identifying the discovery overdue and stating that, unless the Plaintiff complies with the Court's discovery orders, the case may be subject to dismissal. If Defendants have not received a completed PFS within 21 days after serving a Plaintiff with a 20-day notice, Defendants may move the Court for an Order dismissing the Complaint without prejudice. Plaintiff shall have 14 days from the date of Defendants' motion to file a response either certifying that the Plaintiff has served upon Defendants and Defendants have received a completed PFS, and attaching appropriate documentation of receipt or an opposition to Defendants' motion. If a Plaintiff files such a notice, the Plaintiff's claims shall not be dismissed. Unless Plaintiff has served Defendants with a completed PFS or has moved to vacate the dismissal without prejudice within 60 days after entry of any such Order of Dismissal without Prejudice, the order will be converted to a Dismissal with Prejudice upon Defendants' motion.

F. Copies of Records. Defendants or their designee(s) shall make available all records obtained by use of Authorizations to the attorney of record for each individual Plaintiff within 30 days of the receipt of the records. The parties shall meet and confer concerning the mechanism for providing copies of medical records and the payment for such copies.

BY THE COURT:



Hon. Brian R. Martinotti, J.S.C.

**IN RE YAZ®, YASMIN®, OCELLA®
LITIGATION**

**SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: BERGEN COUNTY**

CASE NO. 287

CIVIL ACTION

This Document Relates to All Actions

PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who used Yaz® and/or Yasmin® and/or Ocella®. Whether completing this fact sheet for yourself or for someone else, please assume that "You" means the Yaz® and/or Yasmin® and/or Ocella® user.

In filling out this form, please use the following definitions: (1) "**health care provider**" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric or psychological care or advice, and any pharmacy, weight loss center, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nutritionist, dietician, 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, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone-records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

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

I. CASE INFORMATION

1. Name of person completing this form: _____

YAZ®, Yasmin® Ocella® Plaintiff Fact Sheet
CONFIDENTIAL – SUBJECT TO PROTECTIVE ORDER

2. Please state the following for the civil action that you filed:

- a. Case caption: _____
- b. Docket Number: _____
- c. Court in which action was originally filed: _____
- d. Name, address, telephone number, fax number and email address of principal attorney representing you:
Name: _____
Firm: _____
Address: _____
Telephone Number: _____ Fax Number: _____
E-mail Address: _____

3. If you are completing this Plaintiff Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

- a. Your name: _____
- b. Current Address: _____
- c. In what capacity are you representing the individual or estate: _____
- d. If you were appointed as a representative by a court, state the:
Court Which Appointed You: _____
Date of Appointment: _____
- e. What is your relationship to the individual you represent: _____

**THE REST OF THIS PLAINTIFF FACT SHEET REQUESTS INFORMATION ABOUT
THE PERSON WHO USED YAZ® AND/OR YASMIN® AND/OR OCELLA®**

II. PERSONAL INFORMATION

1. Name: _____
2. Maiden or other names used and dates you used those names: _____

3. Current Address and Date when you began living at this address: _____

4. Identify each address at which you have resided during the last ten (10) years, and the dates you resided at each one.

Address	Dates of Residence

5. Social Security Number: _____
6. Date and Place of Birth: _____
7. Current Marital Status: _____
8. If married, has your spouse filed a loss of consortium or other claim?
Yes _____ No _____
9. Occupation of current spouse: _____
10. Name(s) of current and former spouse(s), date(s) of marriage(s) and dates the marriage(s) were terminated, if applicable, and the nature of the termination (e.g., death, divorce):

11. If you have children, please identify each child's name, address and date of birth.

Child's Name and Address	Date of Birth

12. Identify all schools you attended, starting with high school:

Name of School	Address and Telephone Number	Dates of attendance	Degree Awarded	Major or Primary Field

13. Are you currently employed? Yes _____ No _____

If "Yes", please identify your current employer and position there: _____

- a. Did you ever leave this job for a medical reason? Yes _____ No _____

If "Yes", describe why you left: _____

14. Have you ever served in any branch of the military? Yes _____ No _____

- a. Branch and dates of service: _____

If "Yes", were you ever discharged for any reason relating to your medical, physical or psychiatric condition?

Yes _____ No _____

If "Yes", state what that condition was: _____

b. Have you ever been rejected from military service for any reason relating to your medical, physical, or psychiatric condition?

Yes _____ No _____

If "Yes", state what that condition was: _____

15. Identify each insurance carrier with whom you had health insurance coverage at any time beginning ten (10) years prior to using Yaz® and/or Yasmin® and/or Ocella® (or the age of 13, whichever is later) up to the present, and please include all private insurance and public assistance if applicable:

Name of Insurance Company	Policy Number	Name of Policy Holder/Insured (if different than you)	Approx. Dates of Coverage

16. Have you applied for workers' compensation, social security, or state or federal disability benefits within the past ten (10) years?

Yes _____ No _____

If "Yes", then as to each application, separately state:

a. Date (or year) of application: _____

b. Type of benefits: _____

c. Nature of claimed injury/disability: _____

d. Period of disability: _____

- e. Amount awarded: _____
- f. Basis of your claim: _____
- g. Was claim denied? Yes _____ No _____
- h. To what agency or company did you submit your application:

- i. Claim/docket number, if applicable: _____

17. Have you ever been denied life insurance for reasons relating to your health?

Yes _____ No _____ I don't know _____

If "Yes", please state when the denial occurred, the name of the life insurance company, and the company's reason for denial:

18. Have you ever filed a lawsuit other than the present suit, relating to any bodily injury within the past ten (10) years?

Yes _____ No _____

If "Yes", please explain the nature of the case, where it was filed, and identify your lawyer:

19. In the last 10 years, have you been convicted of or pled guilty to any felony and/or have you been convicted of or pled guilty to any crime that involved an alleged act of dishonesty or providing a false statement?

Yes _____ No _____

If "Yes", please state the charge to which you pled guilty to or were convicted, as well as the court where the action was-pending: _____

III. HEALTH CARE PROVIDERS AND PHARMACIES

1. Identify each doctor or other health care provider who you have seen for medical care and treatment in the past ten (10) years:

Doctor or Health care Provider's Name	Doctor or Health care Provider's Specialty	Address	Reason for Visit	Approx. Dates/Years of Visits

2. Identify each hospital, clinic, or health care facility where you were hospitalized (inpatient, out-patient, or emergency room visit) in the past ten (10) years:

Name	Address and Telephone Number	Admission Date(s)	Reason for Admission Approx dates/years of visits

3. Identify each pharmacy that has dispensed medication to you in the past ten (10) years:

Name of Pharmacy	Address and Telephone Number of Pharmacy	Name of medication dispensed	Approx. Dates/Years You Used Pharmacy

IV. MEDICAL BACKGROUND

1. Current Height: _____
2. Current Weight: _____
3. Approximate weight immediately before using Yaz® and/or Yasmin® and/or Ocella®: _____
4. Approximate weight at the time of your injury: _____
5. Approximate date and age of your first menstrual period: _____
6. **Tobacco Use History:** For the three (3) year period prior to your use of Yaz® and/or Yasmin® and/or Ocella® up to the present Check the answer and fill in the blanks applicable to your history of tobacco use, including cigarettes, cigars, pipes, and/or chewing tobacco/ snuff.

___ I have never used tobacco.

___ I used tobacco in three year period prior to my use of Yaz® and/or Yasmin® and/or Ocella®

Type(s) of tobacco used (cigarettes, cigars, pipes, smokeless tobacco, snuff) _____

Approximate Date tobacco use started: _____

Approximate Amount used: _____

___ I currently use tobacco

Type(s) of tobacco used (cigarettes, cigars, pipes, smokeless tobacco, snuff) _____

Approximate Date tobacco use started: _____

Approximate Amount currently using: on average ___ per day for ___ years

____ I have used different amounts of tobacco at different times (please identify type(s) of tobacco used and dates of use below).

7. **Alcohol Consumption:** For the one (1) year period prior to your use of Yaz® and/or Yasmin® and/or Ocella® up to the present, did you drink alcohol (beer, wine, etc.)?

Yes _____ No _____

If "Yes", fill in the appropriate blank with the number of drinks that best represents your approximate average alcohol consumption during that time:

_____ drinks per week, or

_____ drinks per month; or

_____ drinks per year; or

Other (describe): _____

8. **Caffeine Consumption:** For the one (1) year period prior to your use of Yaz® and/or Yasmin® and/or Ocella® up to the present, did you consume caffeinated beverages (e.g., coffee, tea, soda):

Yes _____ No _____

- (a) If "Yes", fill in the appropriate blank with the number of drinks that best represents your approximate average caffeine consumption during that time:

_____ drinks per week, or

_____ drinks per month; or

_____ drinks per year; or

Other (describe): _____

- (b) State the type of caffeinated beverages consumed (e.g., coffee, tea, soda):

9. State whether in the 30 day period prior to the onset of the injuries for which recovery is sought in this action, you engaged in any prolonged travel (meaning six hours or longer), such as sitting in an airplane or a long car trip, and set forth the date of such travel, and provide a description of such prolonged travel, including date(s) and method(s) of travel:

10. Have you ever been diagnosed with or sought treatment for any of the following conditions? Please select "Yes", "No" or "Unknown" for each condition.

(a) For each condition for which you answer "Yes", please provide the additional information requested in subpart (b):

Condition	Yes	No	Unknown
1. Abnormal genital bleeding			
2. Abnormality of blood vessels or circulatory system			
3. Acne (within one year of use of Yaz®/Yasmin®/Ocella®)			
4. Adrenal insufficiency			
5. Alcoholism			
6. Allergy, such as hay fever, asthma, eczema, hives, sensitivity to drugs and other substances			
7. An abnormal physical condition symptomatic of any disease such as edema of the extremities, pain in the extremities, prolonged (longer than 1 week) subnormal or elevated temperature, recurring headaches, jaundice			
8. Aneurysm			
9. Angina or chest pain			
10. Anorexia or bulimia			
11. Any blood clotting disorder			
12. Arteriovenous malformation (AVM)			
13. Autoimmune disease or condition such as lupus, rheumatoid arthritis, psoriasis, scleroderma, or mixed-connective tissue disorder			
14. Bleeding disorder			
15. Blood clots or thrombosis			

Condition	Yes	No	Unknown
16. Blood disorder or dyscrasia			
17. Brain tumors			
18. Cancer - Breast			
19. Cancer - Cervical			
20. Cancer - Endometrial			
21. Cancer - Other form of Cancer			
22. Cerebrovascular disease or condition			
23. Coronary artery disease or other heart disease			
24. Cystitis			
25. Deep Vein Thrombosis (DVT)			
26. Diabetes			
27. Ectopic Pregnancy			
28. Elevated Cholesterol			
29. Gastrointestinal disease such as gallbladder disease, colitis, intestinal obstruction, liver dysfunction			
30. Glandular disease, such as malfunction of the pancreas, parathyroid, thyroid, adrenal, or pituitary			
31. Gout			
32. Heart attack			
33. Heart valve disease or abnormality			
34. Hepatic dysfunction or active liver disease			
35. Hypercoagulable conditions (e.g., conditions, whether genetic or acquired, in which your blood clots too much)			
36. Hypertension or high blood pressure			
37. Hypotension			
38. Increased C-reactive protein (CRP) levels			
39. Infectious disease, such as tuberculosis, pneumonia, rheumatic fever, syphilis, gonorrhea, typhoid fever, encephalitis, poliomyelitis, malaria or hepatitis			
40. Irregular heart beat, atrial fibrillation, arrhythmia, heart palpitations, tachycardia (rapid heart beat), bradycardia (slow heart beat)			
41. Jaundice			

Condition	Yes	No	Unknown
42. Kidney disease or impaired kidney function			
43. Liver tumor			
44. Migraine or other headaches with neurological symptoms			
45. Mitral valve prolapse			
46. Neurological disease or condition (such as Parkinson's disease, paralysis)			
47. Ovarian cysts			
48. Peripheral vascular disease			
49. Portal Vein Thrombosis			
50. Premenstrual dysphoric disorder (or "PMDD")			
51. Premenstrual syndrome (or "PMS")			
53. Pulmonary Embolism (PE)			
54. Retinal bleed			
55. Rheumatological condition			
56. Seizure disorder or epilepsy			
57. Shortness of breath			
58. Stroke or brain hemorrhage (any type)			
59. Transient Ischemic Attack (TIA)			
60. Varicose veins			
61. Vasculitis			

(b) For each condition for which you answered "Yes" in the previous chart, please provide the information requested below (and attach additional pages as necessary):

Condition	Approximate Date of Onset	Name, Address and Telephone Number of Treating Health Care Provider or Health Care Facility

V. ADDITIONAL MEDICATIONS

1. Do you currently take, or have you ever taken in the last ten (10) years, any of the following medications (generic name is followed brand name products in [brackets]):

Name of Medication	Yes	No	Not sure/ Unknown/ Do Not Recall
1. ACE inhibitors (<i>e.g.</i> , captopril [Capoten], enalapril maleate [Vasotec], lisinopril [Zestril] benazepril [Lotensin], fosinopril [Monopril], moexipril [Univasc], perindopril [Aceon], quinapril [Accupril], ramipril [Altace], trandolapril [Mavik])			
2. Aldosterone antagonists (<i>e.g.</i> , spironolactone [Aldactone], eplerenone [Inspra])			
3. Angiotensin-II receptor antagonists (<i>e.g.</i> , losartan [Cozaar], valsartan [Diovan], irbesartan [Avapro], candesartan [Atacand], eprosartan [Teveten], olmesartan [Benicar], telmisartan [Micardis])			
4. Antibiotics (<i>e.g.</i> , ampicillin, tetracycline, griseofulvin)			
5. Anticoagulants (<i>e.g.</i> , Coumadin, Warfarin, Fragmin, Lovenox, or Heparin)			
6. Anticonvulsants (<i>e.g.</i> , Phenobarbital, phenytoin [Dilantin], carbamazepine [Tegetrol])			
7. Any medications for migraine headaches			
8. Ascorbic acid [Vitamin C]			
9. Asthma/breathing medications			
10. Atorvastatin [Lipitor]			
11. Blood pressure medications			

Name of Medication	Yes	No	Not sure/ Unknown/ Do Not Recall
12. Diuretics			
13. Heart medications (excluding aspirin)			
14. Minocycline (e.g., [Myrac, Dynacin])			
15. NSAIDs (e.g., ibuprofen [Motrin, Advil], naproxen [Naprosyn, Aleve])			
16. Phenylbutazone			
17. Potassium supplement			
18. Potassium-sparing diuretics (e.g., amiloride [Midamor], triamterene [Dyrenium])			
19. Rifampin [Rifadin]			
20. St. John's Wort (hypericum perforatum)			
21. Thyroid Medications			

(a) If you indicated "Yes" for any of the above medications/drugs, please provide the information requested below (and attach additional pages as necessary):

Name of Medication/Drug Used	Dates of Use (approx.)	Name, Address and Telephone Number of prescribing Health Care Provider or Health Care Facility

2. Are there any prescription medications that you have taken on a regular basis in the past ten (10) years?

Yes _____ No _____

(a) If "Yes", please for each prescription medication provide the following information:

Name of Prescription Medication Used on a Regular Basis	The health care provider(s) that Prescribed the Medication	Approximate dates/years taken	Your understanding as to why you were taking the Medication

3. For the 20 days before the onset of the injuries for which recovery is sought in this action, please identify whether you have taken/ingested any of the following:

Name of Medication/Drug/Supplement	Yes	No	Do Not Recall
1. Ephedra			
2. Prescription diet medications			
3. Cocaine/crack cocaine			
4. Attention deficit medications			
5. Heroin or methadone			

Name of Medication/Drug/Supplement	Yes	No	Do Not Recall
6. Marijuana or hashish			
7. LSD, ecstasy, ICE, PCP, MDMA			
8. Amphetamines			
9. Inhaled non-prescriptive substances (e.g., glue or toluene)			
10. Caffeine pills containing stimulants (e.g., No-Doz, Vivarin)			
11. Over the counter appetite suppressants			
12. Dietary supplements			
13. Herbal products			
14. Steroids			

- (a) If you indicated "Yes" for any of the above medications/drugs, please provide the information requested below (and attach additional pages as necessary):

Name of Medication/Drug/Supplement	Approximate Date used (that is <i>within</i> 20 days of your alleged Yaz® and/or Yasmin® and/or Ocella® related injury)

4. *Except for the medications/drugs/supplements identified in question 3 above, for the twenty (20) day period before the onset of the injuries for which recovery is sought in this action, set forth: (a) the name of each and every over the counter and prescription drug product ingested or otherwise used by you (including all vitamins, nutritional supplements, and all herbal and homeopathic medications and remedies); (b) the date of each ingestion or use; (c) the dosage ingested and frequency of use; (d) the purpose for using each such product; (e) the prescribing physician, if any; (f) the pharmacy or store where the product was purchased; and (g) the date of purchase. Attach additional sheets as necessary.*

Name of over-the-counter or prescription drug:	Date(s) of ingestion or use:	Dosage ingested or used and frequency:	Purpose of use:	Prescribing health care provider (if any):	Pharmacy or store where purchased:	Date of purchase:

VI. PREGNANCY HISTORY

1. Have you ever been pregnant? Yes _____ No _____
 - a. If "Yes", state your total number of pregnancies: _____
 - b. If "Yes", state your total number of live births: _____
 - c. If "Yes", indicate below whether during pregnancy, you were diagnosed with or believe you experienced any of the following:

Name of Condition	Yes	No	Unknown	If "Yes", state approx. date(s)
Toxemia				
Gestational Diabetes				
Pre-eclampsia				
Miscarriages				

VII. FAMILY MEDICAL HISTORY

1. Please indicate, to the best of your knowledge, whether your parents, sibling, or grandparents have ever suffered from any of the following:

Condition	Yes	No	I Don't Know
1. Abnormality of blood vessels			
2. Aneurysm			
3. Angina or chest pain			
4. Arteriovenous malformation			
5. Autoimmune disease or condition (e.g., lupus, rheumatoid arthritis, psoriasis, scleroderma, or mixed connective tissue disorder)			
6. Bleeding disorder			
7. Blood clots or thrombosis or any other blood clotting disorder			
8. Blood disorders or dyscrasias (abnormal blood cells)			
9. Brain Tumors			
10. Cancer			
11. Cerebrovascular disease or condition			
12. Deep vein thrombosis (DVT)			
13. Diabetes			
14. Elevated Cholesterol			
15. Glandular disease (such as malfunction of the pancreas, parathyroid, thyroid, adrenal or pituitary)			
16. Heart attack			
17. Heart disease			
18. Heart valve disease or abnormality			
19. Hypercoagulable conditions			
20. Hypertension or high blood pressure			
21. Hypotension			
22. Increased C-reactive protein (CRP) levels			
23. Infectious disease (within the past year, such as tuberculosis, pneumonia, rheumatic fever, typhoid fever, encephalitis, poliomyelitis, malaria, or hepatitis)			

Condition	Yes	No	I Don't Know
24. Irregular heart beat, atrial fibrillation arrhythmia, heart palpitations, tachycardia (rapid heart beat), bradycardia (slow heart beat)			
25. Migraine			
26. Mitral valve prolapse			
27. Neurological disease or condition (such as Parkinson's disease or paralysis)			
28. Peripheral vascular disease			
29. Phlebitis			
30. Portal vein thrombosis			
31. Pulmonary Embolism (PE)			
32. Retinal bleed			
33. Rheumatological condition			
34. Seizure disorder or epilepsy			
35. Stroke of any type or brain hemorrhage			
36. Transient ischemic attack (TIA)			
37. Varicose veins			
38. Vasculitis			

(a) For each condition for which you answered "Yes" in the immediately preceding chart, please provide the information requested below (and attach additional pages as necessary):

Condition	Date of Onset (approx.)	Relationship to You	Treatment and Outcome (If known)	Name and Address of Treating health care provider or health care facility (If known)

VIII. USE OF CONTRACEPTIVES OTHER THAN YAZ® AND/OR YASMIN® AND/OR OCELLA®

1. Did you use contraceptives before your use of YAZ® and/or Yasmin® and/or Ocella®?
 Yes ___ No ___
2. If Yes, what contraceptives have you used in the past *before* you used YAZ® and/or Yasmin® and/or Ocella®? Check all that apply below.

Form of Contraception	Yes	No	Unknown
(a) Oral contraceptives (e.g., birth control pills)			
(b) Norplant (e.g., implants under skin)			
(c) Depo-Provera® (the shot)			
(d) NuvaRing®			
(e) Transdermal contraceptives (e.g., Ortho Evra®)			
(f) Intrauterine device (IUD)			
(g) Contraceptive sponge			
(h) Diaphragm			
(i) Condoms			
(j) Spermicide			
(k) Rhythm method			
(l) Other			

For each "Yes" you have checked above, provide the following:

Form of contraception (*i.e.*, precise name/type of product): _____
 Approx length of use (*i.e.*, months/years): _____
 Pharmacy where prescription was filled (if applicable): _____
 Health care provider who prescribed it: _____

Form of contraception (*i.e.*, precise name/type of product): _____
 Approx length of use (*i.e.*, months/years): _____
 Pharmacy where prescription was filled (if applicable): _____
 Health care provider who prescribed it: _____

Form of contraception (*i.e.*, precise name/type of product): _____
 Approx length of use (*i.e.*, months/years): _____
 Pharmacy where prescription was filled (if applicable): _____
 Health care provider who prescribed it: _____

IX. YAZ® AND/OR YASMIN® AND/OR OCELLA® USE

1. Have you ever used Yaz®? Yes _____ No _____
2. Have you ever used Yasmin®? Yes _____ No _____
3. Have you ever used Ocella®? Yes _____ No _____

If "Yes", identify:

a) Date(s) of use: _____

b) Provide in the chart below the name(s) and address(es) of the health care provider(s) who prescribed or provided Yaz® and/or Yasmin® and/or Ocella® to you:

Name of health care provider(s)	Address of health care provider(s)

c) Provide in the chart below the name(s) and address(es) of the pharmacy(ies) or other store(s) or location(s) from which you obtained Yaz® and/or Yasmin® and/or Ocella® (if samples were provided, see no. 5, below):

Name of Pharmacy or Other Store/Location	Address

4. Do you claim that you took Yaz® and/or Yasmin® and/or Ocella® to treat PMDD, PMS or acne?

PMDD: Yes _____ No _____

PMS: Yes _____ No _____

Acne: Yes _____ No _____

If you checked "Yes" for PMDD or PMS in the preceding questions, please state whether you saw a psychiatrist, psychologist or other mental health care provider for PMDD, PMS or the symptoms of PMDD or PMS or any psychiatric and/or psychological condition(s) relating to PMDD or PMS in the last ten (10) years:

Name of psychiatrist, psychologist or other mental health care provider	Address and Telephone	Reason for Treatment	Approx. Dates/ Years of Treatment/ Visits

5. Did you receive any samples of Yaz® and/or Yasmin® and/or Ocella®?

Yes _____ No _____ I don't recall _____

If "Yes", please state the following:

a) Who gave you the sample(s): _____

b) When were samples provided: _____

c) How many samples did you get? _____

6. Were you given any written instructions, including any prescriptions, packaging, package inserts, literature, or dosing instructions with your Yaz® and/or Yasmin® and/or Ocella®?

Yes _____ No _____ I don't recall _____

If "Yes", who gave you the instructions? _____

7. Were you given any oral instructions regarding your use of Yaz® and/or Yasmin® and/or Ocella®?

Yes _____ No _____ I don't recall _____

If "Yes", who gave you the instructions? _____

8. Do you have in your possession or does your attorney have the packaging from the Yaz® and/or Yasmin® and/or Ocella® you alleged to have used?

Yes _____ No _____

If "Yes", who currently has custody of the Yaz® and/or Yasmin® and/or Ocella® packaging? _____

9. Do you know the lot number(s) for any of the Yaz® and/or Yasmin® and/or Ocella® you received?

Yes _____ No _____

If "Yes", what is/are the lot number(s): _____

10. Do you know the expiration date for any of the Yaz® and/or Yasmin® and/or Ocella® you received?

Yes _____ No _____

If "Yes", when is/was/were the expiration date(s): _____

11. Have you ever seen any advertisements (e.g., in magazines or television commercials) for Yaz® and/or Yasmin® and/or Ocella®?

Yes _____ No _____ I don't recall _____

If "Yes," identify the advertisement or commercial, and approximately when you saw the advertisement or commercial: _____

12. Other than through your attorneys, have you had or do you believe you have had any communication, oral or written, with any of the Defendants or their representatives (including E-mail, Text Messages, E-Minders to/from you and any of the Defendants including through websites for Yaz® and/or Yazmin® and/or Ocella® and/or signing up for an on-line program)?

Yes _____ No _____ I do not recall _____

If "Yes," set forth the date of the communication, the method of communication, the name of the representative you communicated with, and the substance of the communication between you and any representatives of the Defendants: _____

X. INJURIES & DAMAGES

1. Are you claiming any injury as a result of taking Yaz® and/or Yasmin® and/or Ocella®?

Yes _____ No _____

If "Yes," please describe in detail your physical injury(ies) you claim were caused as result of your use of Yaz® and/or Yasmin® and/or Ocella®:

a. When did this/these injury(ies) occur? _____

b. Were there any witnesses when your injury occurred or for the period of one (1) hour before your injury occurred, and if so, please state his/her/their name(s), address(es) and his/her/their relationship to you?

c. If you were taken to a doctor or health care facility (e.g., hospital or clinic) to be treated for the injury(ies), state the name and address of the persons, police department, fire department, emergency medical workers, or ambulance company who took you to the doctor or health care facility:

Name	Address

d. Were you hospitalized for this/these injury(ies)? _____

Yes _____ No _____

If "Yes", please provide the following information:

Approximate date(s) of hospital admission	Approximate date(s) of discharge	Hospital name(s) and address(es):

2. Do you claim that your use of Yaz® and/or Yasmin® and/or Ocella® caused or aggravated any psychiatric and/or psychological condition(s)?

Yes _____ No _____

(a) If "Yes", please state the following as it pertains to your treatment of any psychiatric and/or psychological condition(s) in the last ten (10) years:

Name of psychiatrist, psychologist or other mental health care provider	Address and Telephone	Reason for Treatment	Approx. Dates/ Years of Treatment/ Visits

3. **NOTE: ANSWER THIS QUESTION ONLY** if you are alleging and claiming that you suffered a stroke or other brain injury or cognitive impairment as a result of your Yaz® and/or Yasmin® and/or Ocella® use. If so, then please answer the following:

(a) Have you been treated in the last ten (10) years for any cognitive or learning problem?

Yes _____ No _____

(b) If "Yes", please state the following as it pertains to your treatment for any cognitive or learning problem in the last ten (10) years:

Name of treatment provider	Address and Telephone	Reason for Treatment	Approx. Dates/Years of Treatment/ Visits

4. Are you making a claim for lost wages or lost earning capacity?

Yes _____ No _____

(a) If "Yes", state for the last five (5) years the Annual gross income you derived from your employment:

Year	Annual gross income

5. If you are making a claim for lost wages (or are claiming a stroke, other brain injury, or cognitive impairment) identify the following for each employer you have had in the last five (5) years:

Name and Address of Employer	Approx. Dates of Employment	Occupation/Job Title	Supervisor	Reason for Leaving

6. Have you had any communications with your health care providers, orally or in writing, about whether your condition is related to your use of Yaz® and/or Yasmin® and/or Ocella®?

Yes _____ No _____ I don't recall _____

- (a) If "Yes", please identify the name, address and approximate date of communication with said health care provider:

7. Have you spent any money as a result of using Yaz® and/or Yasmin® and/or Ocella®?

Yes _____ No _____

- (a) If "Yes", please identify and itemize all out-of-pocket expenses you have incurred:

XI. FACT WITNESSES

1. Please identify all persons who you believe possess information concerning your injury(ies) and current medical conditions, other than your health care providers, and please state their name, address and his/her/their relationship to you (attach additional pages as necessary):

Name	Address	Relationship to You

XII. DOCUMENT DEMANDS

A. AUTHORIZATIONS

- 1) **Health care Authorizations** – For each health care provider identified in Sections III; IV; V; VII; VIII; IX and X, please provide a completed and signed (but undated) Health care Authorization in the form attached as **Exhibit “A.”**

- 2) **Tax Return 4506 and 4506-T IRS Forms** –
 - a) Only if you answered "Yes" to question X.4 in the PFS and are asserting a claim for lost wages or a reduction in lost earning capacity, please provide a completed and signed IRS Form 4506 and 4506-T attached as **Exhibit “B”** for each year identified in your answer to question X.4.

 - b) If you answered "No" to question X.4 in the PFS and are not asserting a wage loss claim or a reduction in lost earning capacity, you are not required to provide IRS Form 4506 / 4506-T.

- 3) **Authorizations for the Release of Employment Records** – If you are 1) asserting a claim for lost wages or a reduction in or lost earning capacity or 2) claiming a stroke, other brain injury, or cognitive impairment, please provide a completed and signed Employment Authorization attached as **Exhibit “C”** for each employer identified in your answer question X.5.

- 4) **Authorization for Release of Workers' Compensation Records** – If you answered "Yes" to question II.16 in the PFS, stating that you applied for workers' compensation within the past ten (10) years, please provide a completed and signed (but undated) Authorization for Release of Workers' Compensation Records for each agency or company you submitted your application to in the last 10 years in the form attached as **Exhibit “D.”**

- 5) **Authorization for Release of Disability Records** - If you answered "Yes" to question II.16 in the PFS, stating that you applied for disability within the past ten (10) years, please provide a completed and signed (but undated) Authorization for Release for each agency or company you submitted your application to in the last 10 years in the form attached as **Exhibit “E.”**

- 6) **Educational Records** - If you are 1) asserting a claim for lost wages or a reduction in or lost earning capacity or 2) claiming a stroke, other brain injury, or cognitive impairment, please provide a completed and signed Educational Authorization attached as **Exhibit “F”** for each educational institution for each educational institution that you listed in response to question II.12.

7) **Insurance Records Authorization**- For each company listed in your response to question II.15 in the PFS, please provide a completed and signed (but undated) Authorization for Release of Insurance Records in the form attached as **Exhibit "G"**.

B. FEDERAL DISCLOSURES REQUIRED PURSUANT TO 42 U.S.C. § 1395y(b)(7) and (b)(8)

Starting on January 1, 2010, Defendants must report to the federal government certain information about every Plaintiff making a personal injury claim. Please complete the Federal Disclosure statement attached to the end of this Plaintiff Fact Sheet as **Exhibit "H"**.

C. OTHER RELEVANT DOCUMENTS

Documents in your possession, including writings on paper or in electronic form (if you have any of the following materials in your custody or possession, please indicate which documents you have and attach a copy of them to this Plaintiff Fact Sheet):

1. All non-privileged documents you reviewed that assisted you in the preparation of the answers to this Plaintiff Fact Sheet. Yes _____ No _____
2. A copy of all medical records and/or documents relating to the use of Yaz® and/or Yasmin® and/or Ocella®; from any hospital or health care provider who treated you in the past 10 years and who treated you for any disease, condition or symptom referred to in any of your responses to the questions above and concerning any condition you claim is related to the use of Yaz® and/or Yasmin® and/or Ocella®, including, but not limited to, all imaging studies of any part of your body that relate in any manner to the diagnosis, treatment, care or management of your condition and the injuries alleged in your Complaint. Yes _____ No _____
3. If you have been the claimant or subject of any workers' compensation, social security or other disability proceeding, all documents relating to such proceeding. Yes _____ No _____
4. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of Yaz® and/or Yasmin® and/or Ocella®. Yes _____ No _____
5. Copies of advertisements or promotions for Yaz® and/or Yasmin® and/or Ocella® and articles discussing Yaz® and/or Yasmin® and/or Ocella®. Yes _____ No _____
6. Copies of the entire packaging, including the box and label for Yaz® and/or Yasmin® and/or Ocella® (plaintiffs or their counsel must maintain the originals of the items requested in this subpart). Yes _____ No _____

7. All documents relating to your purchase of Yaz® and/or Yasmin® and/or Ocella®, including, but not limited to, receipts, prescriptions, prescription records, containers, labels, or records of purchase. Yes _____ No _____
8. All documents known to you and in your possession which mention Yaz® and/or Yasmin® and/or Ocella® or any alleged health risks or hazards related to Yaz® and/or Yasmin® and/or Ocella® in your possession at or before the time of the injury alleged in your Complaint, other than legal documents, documents provided by your attorney or documents obtained or created for the purpose of seeking legal advice or assistance. Yes _____ No _____
9. All documents in your possession or anyone acting on your behalf (not your lawyer) obtained directly or indirectly from any of the Defendants. Yes _____ No _____
10. All documents constituting any communications or correspondence between you and any representative of the Defendants. Yes _____ No _____
11. All photographs, drawing, journals, slides, videos, DVDs or any other media relating to your alleged injury, and representative photographs of your life after the incident. Yes _____ No _____
12. Copies of all documents you (and not your lawyer) obtained from any source related to Yaz® and/or Yasmin® and/or Ocella® or to the alleged effects of using Yaz® and/or Yasmin® and/or Ocella®. Yes _____ No _____
13. If you claim you have suffered a loss of earnings or earnings capacity, your federal tax returns for each of the last five (5) years or W-2s for each of the last five years. Yes _____ No _____
14. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care providers. Yes _____ No _____
15. All public statements made by or on behalf of you relating to this litigation in your possession. Yes _____ No _____
16. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable). Yes _____ No _____
17. Decedent's death certificate and autopsy report (if applicable). Yes _____ No _____

XIII. DECLARATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry, that I have supplied all the documents requested in Part XII of this Plaintiff Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the Authorizations attached to this declaration.

Date: _____

Signature

FP01/ 6337668.1

EXHIBIT-A

(Healthcare Authorization)

LIMITED AUTHORIZATION TO DISCLOSE AND HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO: _____

Patient Name: _____

DOB: _____

SSN: _____

I _____, hereby authorize you to release and furnish to: **Sidley Austin/Eckert Seamans/Williams & Connolly/Drinker Biddle & Reath/Litigation Management Inc. COPIES ONLY** of the following information:

- * All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
 - * * All reports of autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
 - * All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
 - * All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
 - * All billing records including all statements, itemized bills, and insurance records.
1. To my medical provider: this authorization is being forwarded by, or on behalf of, attorneys for the defendants and has been approved by the Court supervising this litigation. This authorization is for the sole purpose of allowing copies of my medical records to be provided to the defendants in this litigation. It does not allow discussions of my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition.
 2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
 3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.
 4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicate above.
 5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name: _____ (plaintiff/representative)

Signature: _____

_____ Date

EXHIBIT-B

(IRS Forms)

Request for Copy of Tax Return

▶ Request may be rejected if the form is incomplete or illegible.

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 original 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.	

Caution. If the tax return is being mailed to a third party, ensure that you have filled in line 6 and line 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.

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

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.

<u>12/31/2002</u>	<u>12/31/2003</u>	<u>12/31/2004</u>	<u>12/31/2005</u>
<u>12/31/2006</u>	<u>12/31/2007</u>	<u>12/31/2008</u>	

8 Fee. There is a \$57 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	\$ 57.00
b Number of returns requested on line 7	7
c Total cost. Multiply line 8a by line 8b	\$ 399.00

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. **Note.** For tax returns being sent to a third party, this form must be received within 120 days of signature date.

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

Form **4506-T**

(Rev. January 2010)

Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ Request may be rejected if the form is incomplete or illegible.

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can also call 1-800-829-1040 to order a transcript. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return**. There is a fee to get a copy of your return.

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 transcript or tax information 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 information.

Caution. If the transcript is being mailed to a third party, ensure that you have filled in line 6 and line 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ 1040

- a **Return Transcript**, which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days
- b **Account Transcript**, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 30 calendar days.
- c **Record of Account**, which is a combination of line item information and later adjustments to the account. Available for current year and 3 prior tax years. Most requests will be processed within 30 calendar days

7 **Verification of Nonfiling**, which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2007, filed in 2008, will not be available from the IRS until 2009. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 45 days

Caution. If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **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 four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

12/31/2005 12/31/2006 12/31/2007 12/31/2008

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 information 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-T on behalf of the taxpayer. **Note.** For transcripts being sent to a third party, this form must be received within 120 days of signature date.

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

EXHIBIT-C

(Employment Authorizations)

**HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508
EMPLOYMENT AUTHORIZATION**

TO: _____
Name of Employer _____

Address, City State and Zip Code _____

RE: Employee Name: _____ AKA: _____
Date of Birth: _____ Social Security Number: _____
Address: _____

I authorize the disclosure of my employment records including any medical information protected by HIPAA, 45 CFR 164.508, for the purpose of review and evaluation in connection with a legal claim. I expressly request that all entities identified above disclose full and complete records including the following:

This will authorize you to furnish copies of all applications for employment; resumes; records of all positions held; job descriptions of positions held; wage and income statements and/or compensation records; wage increases and decreases; performance evaluations, reviews and reports; transfers, statements and comments of fellow employees; all documents relating to discipline including warnings, reprimands, suspensions, terminations, and all other forms of discipline; attendance records; W-2s, worker's compensation files; all medical records, x-rays and test results; any physical examination records; all documents relating to my absences, illnesses and injuries; any records pertaining to claims made relating to health, disability or accidents in which I was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf; and any other records relating to my employment and/or in my personnel file.

Information about HIV/AIDS and alcohol/substance abuse may be disclosed.

I authorize you to release the information to:

Name (Records Requestor)

Street Address City State and Zip Code

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, either by you or another party, you must produce such information to the Records Requestor at that time.

I acknowledge the right to revoke this authorization by writing to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization expires December 31, 2011 or at the conclusion of the case, whichever occurs first.

Signature of Employee or Personal Representative Date Name of Employee or Personal Representative

Description of Personal Representative's Authority to Sign for Employee (attach documents that show authority)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Employee is physically unable to provide a signature. I personally witnessed that the Employee understood the nature of this authorization and freely gave her verbal consent to release her medical records.

EXHIBIT-D

(Workers' Comp. Authorizations)

**AUTHORIZATION FOR RELEASE OF
WORKERS' COMPENSATION RECORDS**

To:

Name

Address

City, State and Zip Code

This will authorize you to furnish copies of any and all workers' compensation records of any sort, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

Name of Claimant

whose date of birth is _____ and whose social security number is

_____.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

Name of Representative

Records Requester

Representative Capacity (e.g., attorney, records requestor, agent, etc.)

Street Address

City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____

Claimant Signature
[NAME]

Date: _____

Witness Signature

EXHIBIT-E

(Disability Authorizations)

**AUTHORIZATION FOR RELEASE OF
DISABILITY CLAIMS RECORDS**

To:

Name

Address

City, State and Zip Code

This will authorize you to furnish copies of any and all records of disability claims of any sort, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

Name of Claimant

whose date of birth is _____ and whose social security number is

_____.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

Name of Representative

Records Requester

Representative Capacity (e.g., attorney, records requestor, agent, etc.)

Street Address

City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____

Claimant/Guardian/Personal Representative
Signature
[NAME]

Date: _____

Witness Signature

EXHIBIT-F

(Educational Authorizations)

**AUTHORIZATION FOR RELEASE OF
EDUCATIONAL RECORDS**

To:

Name

Address

City, State and Zip Code

This will authorize you to furnish copies of all school records including, but not limited to, test results, test scores, report cards, or other school grading material, attendance records, physicals and other health-related, including but not limited to any physicians, nursing or allied health professional reports, records or notes, which may be in your possession.

Name of Student

whose date of birth is _____ and whose social security number is _____.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

Name of Representative

Records Requester

Representative Capacity (e.g., attorney, records requestor, agent, etc.)

Street Address

City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgement at the bottom of this authorization.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____

Student
[NAME]

Date: _____

Witness Signature

EXHIBIT-G

(Insurance Authorizations)

**AUTHORIZATION FOR RELEASE OF
INSURANCE RECORDS**

To:

Name of Insurer

Address

City, State and Zip Code

This will authorize you to furnish copies of all forms regarding insurance claims applications and benefits and all medical, health, hospital, physicians, nursing or allied health professional reports, records, notes or invoices and bills, which may be in your possession.:

Name of Insured

whose date of birth is _____ and whose social security number is _____.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

Name of Representative

Records Requester

Representative Capacity (e.g., attorney, records requestor, agent, etc.)

Street Address

City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgement at the bottom of this authorization.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____

Insured
[NAME]

Date: _____

Witness Signature

EXHIBIT-H

(Federal Disclosure)

Federal Disclosure Requirements
(required by 42 U.S.C. § 1395y(b)(7) and (b)(8))

Starting on January 1, 2010, defendants must report to the federal government certain information about every plaintiff making a personal injury claim. Please complete the following form.

If you are filling this out in a representative capacity, the information should be for the user of the medication, not yourself.

Full Legal Name: _____

Date of Birth: _____

Gender: _____

Social Security Number: _____

Health Insurance
Claim Number (HICN): _____

Are you (or the person taking the medication) eligible to receive Medicare benefits?

Yes _____

No _____

If so, on what date did you (or the person taking the medication) become eligible to receive Medicare benefits?
