



IN THE COURT OF COMMON PLEAS  
PHILADELPHIA COUNTY, CIVIL TRIAL DIVISION

IN RE: YAZ®, YASMIN®, OCELLA®  
PRODUCT LIABILITY LITIGATION

SEPTEMBER TERM, 2009

APPLICABLE TO ALL CASES

NO. 1307

DOCKETED  
COMPLEX LIT CENTER

JAN 7 2010

CASE MANAGEMENT ORDER NO. 4 (a)  
(Plaintiff Fact Sheet and Authorizations)

J. STEWART

THIS MATTER, having been opened to the Court by counsel for the Parties, and the Parties having consented, stipulated and agreed to amend *Case Management Order No. 4 (CMO-4)* dated December 11, 2009, and good cause appearing therefore;

IT IS, on this 6th day of Jan, 2010, hereby **ORDERED** as follows:

**I. AUTHORIZATIONS FOR THE RELEASE OF EMPLOYMENT AND EDUCATIONAL RECORDS**

Plaintiffs' obligations to provide Defendants with *Employment* and *Educational Authorizations* with the Plaintiff Fact Sheet ("PFS") in CMO-4 section II(B)(b)(3) and II(B)(b)(6) is hereby amended as follows:

Plaintiff shall provide to Defendants, with the PFS, Employment Authorizations for each employer identified in Plaintiff's response to question X.5 of the PFS and Educational Authorizations for each educational institution that Plaintiff listed in response to question II.12 in the PFS, only if the Plaintiff is claiming that she suffered a stroke, other brain injury, or cognitive impairment as a result of Yaz® and/or Yasmin® and/or Ocella® use or if Plaintiff is asserting a claim for lost wages or a reduction in or lost earning capacity . If a Plaintiff is not claiming that she suffered a stroke, other brain injury, or cognitive impairment as a result of Yaz® and/or Yasmin® and/or Ocella® use and is not asserting a claim for lost wages or a reduction in or lost earning capacity then she does not have to provide Educational or

Employment Authorizations to Defendants.

**II. SERVICE OF THE PLAINTIFF FACT SHEET**

**A. The PFS**

The PFS referred to in CMO-4 is attached as Exhibit "1".

**B. PFS Due Date to Defendants**

CMO-4 section II(A)(1)(b) relating to the PFS is hereby amended as follows:

1. **Currently Pending Cases** - For cases currently pending before this Court in the above-captioned consolidated litigation, the Plaintiff shall serve Defendants a completed PFS within **seventy-five (75)** days of the date that this CMO is entered (not seventy-five (75) days of the date that CMO-4 was entered);

2. **Newly Filed Cases** - For all newly filed cases before this Court in the above-captioned consolidated litigation, the Plaintiff shall serve Defendant a completed PFS within **seventy-five (75)** days of the date on which service of the Writ, Complaint or Short Form Complaint is made on the first Defendant.

3. **Service of the PFS**

a) Plaintiffs shall serve the PFS, Authorizations and documents produced in response to the document requests in the PFS, upon Defendants' Liaison Counsel **in**

**PDF format on a CD-Rom:**

Albert G. Bixler, Esquire  
Eckert Seamans Cherin & Mellott, LLC  
Two Liberty Place  
50 South 16th Street, 22nd Floor  
Philadelphia, PA 19102  
Phone: (215) 851-8412

b) Service of the PFS upon BARR PHARMACEUTICAL, INC., BARR LABORATORIES, INC., TEVA PHARMACEUTICAL INDUSTRIES LTD., TEVA PHARMACEUTICALS USA, INC. shall be set forth in a subsequent Case Management Order.

c) Plaintiffs shall also serve a copy of the PFS without attachments to Plaintiffs' Liaison Counsel at YazLit@lfsblaw.com.

All provisions of CMO-4 other than those amended herein shall remain unchanged and in full force and effect.

**IT IS SO ORDERED, BY THE COURT**



THE HONORABLE SANDRA MAZER MOSS

# EXHIBIT-1

(CMO No. 4(a))

**IN THE COURT OF COMMON PLEAS  
PHILADELPHIA COUNTY**

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<b>IN RE: YAZ®/YASMIN®/OCELLA®</b>	:	
<b>PRODUCT LIABILITY LITIGATION</b>	:	<b>SEPTEMBER TERM 2009</b>
	:	
	:	<b>NO. 1307</b>
	:	
<b>THIS DOCUMENT APPLIES TO ALL CASES</b>	:	
	:	

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**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: \_\_\_\_\_
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 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 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 \_\_\_\_\_

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: \_\_\_\_\_

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. HEALTHCARE PROVIDERS AND PHARMACIES**

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

<b>Doctor or Healthcare Provider's Name</b>	<b>Doctor or Healthcare Provider's Specialty</b>	<b>Address</b>	<b>Reason for Visit</b>	<b>Approx. Dates/Years of Visits</b>

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:

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

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

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


**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).

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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 \_\_\_\_\_

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): \_\_\_\_\_

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

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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 methods of travel:

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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. 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			
16. Blood disorder or dyscrasia			

<b>Condition</b>	<b>Yes</b>	<b>No</b>	<b>Unknown</b>
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 gall bladder 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			
42. Kidney disease or impaired kidney function			

<b>Condition</b>	<b>Yes</b>	<b>No</b>	<b>Unknown</b>
43. Liver tumor			
44. Migraine or other headaches with neurological symptoms			
45. Mitral valve prolapsed			
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):

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

**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 (e.g., captopril [Capoten], enalapril maleate [Vasotec], lisinopril [Zestril] benazepril [Lotensin], fosinopril [Monopril], moexipril [Univasc], perindopril [Aceon], quinapril [Accupril], ramipril [Altace], trandolapril [Mavik])			
2. Aldosterone antagonists (e.g., spironolactone [Aldactone], eplerenone [Inspra])			
3. Angiotensin-II receptor antagonists (e.g., losartan [Cozaar], valsartan [Diovan], irbesartan [Avapro], candesartan [Atacand], eprosartan [Teveten], olmesartan [Benicar], telmisartan [Micardis])			
4. Antibiotics (e.g., ampicillin, tetracycline, griseofulvin)			
5. Anticoagulants (e.g., Coumadin, Warfarin, Fragmin, Lovenox, or Heparin)			
6. Anticonvulsants (e.g., 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			

<b>Name of Medication</b>	<b>Yes</b>	<b>No</b>	<b>Not sure/Unknown /Do Not Recall</b>
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			

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

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

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

Yes \_\_\_\_\_ No \_\_\_\_\_

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

Name of Prescription Medication Used on a Regular Basis	The Doctor/ Doctors 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			

(b) 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 <u>within</u> 20 days of your alleged Yasmin/Yaz 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.*



**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:

<b>Condition</b>	<b>Yes</b>	<b>No</b>	<b>I Don't Know</b>
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)			

<b>Condition</b>	<b>Yes</b>	<b>No</b>	<b>I Don't Know</b>
24. Irregular heart beat, atrial fibrillation arrhythmia, heart palpitations, tachycardia (rapid heart beat), bradycardia (slow heart beat)			
25. Migraine			
26. Mitral valve prolapsed			
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			

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):

<b>Condition</b>	<b>Date of Onset (approx.)</b>	<b>Relationship to You</b>	<b>Treatment and Outcome (If known)</b>	<b>Name and Address of Treating Health Care Provider or Health Care Facility (If known)</b>

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

1) Why were you taking YAZ®, Yasmin® or Ocella®? (if applicable, you may choose more than one answer):

\_\_\_\_\_ Birth control

\_\_\_\_\_ Acne treatment

\_\_\_\_\_ PMDD

\_\_\_\_\_ Other

2) (a) State whether prior to taking YAZ®, Yasmin® or Ocella® you used other methods of birth control?

Yes \_\_\_\_\_ No \_\_\_\_\_

If your answer is “Yes” to question 2(a), then complete both tables 2(b) and 3(a) below:

(b) Please indicate which of the methods of birth control you used prior to taking YAZ®, Yasmin® or Ocella® for birth control:

<b>Form of Contraception</b>	<b>Yes</b>	<b>No</b>	<b>Unknown</b>
(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)			

(c) For each “Yes” you have checked in table 2(b) above, provide the following:

<b>Form of contraception (e.g., precise name/type of product if known)</b>	<b>Approximate date of last use, if known</b>	<b>Pharmacy or store where prescription was filled</b>	<b>Prescribing physician (if any)</b>


(d) For each method of birth control listed in the table 2(b) or 2(c) above, please state whether you stopped using the method of birth control for any of the following reasons:

\_\_\_\_\_ was not effective;

\_\_\_\_\_ you had problems with tolerability;

\_\_\_\_\_ you experienced side-effects from it;

\_\_\_\_\_ other

3) (a) If you used other methods of birth control prior to using YAZ®, Yasmin® or Ocella® please state whether, prior to taking YAZ®, Yasmin® or Ocella®, you ever used:

Form of Contraception	Yes	No
(a) Condoms		
(b) Contraceptive sponge		
(c) Diaphragm		
(d) Spermicide		
(e) Rhythm method		

(b) For each method of birth control listed in table 3(a) above, please state whether you stopped using the method for any of the following reasons:

\_\_\_\_\_ was not effective;

\_\_\_\_\_ you had problems with tolerability;

\_\_\_\_\_ you experienced side-effects from it; or,

\_\_\_\_\_ other

For each “Yes” you have checked in table 3(a), provide the following for each method of contraception (EXCEPT for the “Rhythm Method”):

Form of contraception (e.g., precise name/type of product, if known)

- (c) If you checked “Yes” in table 3(a) to having used a Diaphragm prior to taking YAZ®, Yasmin® or Ocella®, please state the name and address of any physician that prescribed the Diaphragm:

Name of Diaphragm Prescribing Physician	Address

**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 healthcare provider(s) who prescribed or provided Yaz® and/or Yasmin® and/or Ocella® to you:

Name of healthcare provider(s)	Address of healthcare provider(s)

c) Provide in the chart below the name(s) and addresses of the pharmacies or other store(s) or location(s) from which you obtained Yaz® and/or Yasmin® and/or Ocella® (if samples were provided, see no. 2, 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 healthcare 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 healthcare 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 \_\_\_\_\_

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®, Yazmin® or Ocella® and/or signing up for an on-line program)?

Yes \_\_\_\_\_ No \_\_\_\_\_ I do not recall \_\_\_\_\_

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: \_\_\_\_\_

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**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®:

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

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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?

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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 \_\_\_\_\_

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 healthcare 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 \_\_\_\_\_

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 \_\_\_\_\_

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 healthcare 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 \_\_\_\_\_

If "Yes", please identify the name, address and approximate date of communication with said healthcare provider:

\_\_\_\_\_

\_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_

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




## **XII. DOCUMENT DEMANDS**

### **A. AUTHORIZATIONS**

1) **Healthcare Authorizations** - For each medical provider identified in Sections III; IV; V; VI; VIII; IX and X of the PFS, please provide a completed and signed (but undated) Healthcare 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 "F."**

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. § 1395v(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 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 attach a copy to this Fact Sheet):

1. All non-privileged documents you reviewed that assisted you in the preparation of the answers to this Fact Sheet.
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 healthcare 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.
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.
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®.
5. Copies of advertisements or promotions for Yaz® and/or Yasmin® and/or Ocella® and articles discussing Yaz® and/or Yasmin® and/or Ocella®.
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).
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.

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.
9. All documents in your possession or anyone acting on your behalf (not your lawyer) obtained directly or indirectly from any of the Defendants.
10. All documents constituting any communications or correspondence between you and any representative of the Defendants.
11. All photographs, drawing, journals, slides, videos, DVDs or any other media relating to your alleged injury or your life after the incident.
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®.
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.
14. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other healthcare providers.
15. All public statements made by or on behalf of you relating to this litigation in your possession.
16. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable).
17. Decedent's death certificate and autopsy report (if applicable).

**XIII. DECLARATION**

I declare under penalty of perjury subject to 18 Pa. C.S. § 4904 that all of the information provided in this Plaintiffs' 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 IX of this Plaintiffs' 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.

Further, by signing below, I waive notice under the Pennsylvania Rules of Civil Procedure, or other applicable law or rule, of subpoenas or other requests for production of medical records directed to health care providers for whom I have provided Authorizations in connection with this Plaintiff's Fact Sheet.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature

# 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: [Firm Name and/or Third-party record provider] 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. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive and additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing 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 at a deposition or trial".**
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)

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.	

**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  
*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>	<u> / /</u>

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	7
c Total cost. Multiply line 8a by line 8b	\$234.00

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.

<b>Sign Here</b>	Signature (see instructions)	Date	Telephone number of taxpayer on line 1a or 2a (    )    -    -
	Title (if line 1a above is a corporation, partnership, estate, or trust)		
	Spouse's signature	Date	

Form **4506-T**

**Request for Transcript of Tax Return**

(Rev. January 2008)  
Department of the Treasury  
Internal Revenue Service

- ▶ 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. 1545-1872

**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: DO NOT SIGN** this form if a third party requires you to complete Form 4506-T, and lines 6 and 9 are blank.

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. 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. 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 2006, filed in 2007, will not be available from the IRS until 2008. 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.

<b>Sign Here</b>	Signature (see instructions)	Date	Telephone number of taxpayer on line 1a or 2a (    )	
	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.

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# 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?

\_\_\_\_\_