

IN RE	:	COURT OF COMMON PLEAS	
	:	PHILADELPHIA COUNTY	DOCKETED
REGLAN [®] /METOCLOPRAMIDE	:		COMPLEX LIT CENTER
LITIGATION	:	JANUARY TERM, 2010	JUN 16 2010
	:	NO. 1997	
<i>This Document Relates to All Cases</i>	:		J. STEWART

CASE MANAGEMENT ORDER NO. 8:
REVISIONS TO CMO NO. 1 (AMENDED MASTER LONG FORM COMPLAINT AND SHORT FORM COMPLAINTS), CONSENT OF DISMISSAL OF PARTIES NOT NAMED AS DEFENDANTS IN SHORT FORM COMPLAINTS, AFFIDAVIT IN LIEU OF RESPONSE TO PLAINTIFFS' INTERROGATORIES AND AUTHORIZATIONS AND PROCEDURE FOR RELEASE OF RECORDS

I. SCOPE OF THIS ORDER

This Case Management Order shall govern all cases that are presently pending or hereafter filed in the Philadelphia Court of Common Pleas which become part of the program of coordinated pretrial proceedings relating to the prescription drug Reglan[®] and/or metoclopramide (the "Reglan[®]/metoclopramide Litigation"). This Order recognizes the fact that Plaintiffs have filed a First Amended Master Long Form Complaint and clarifies the manner in which certain deadlines set forth in Case Management Order ("CMO") No. 1 will be calculated. This Order also clarifies the time and manner in which Parties shall respond to: (1) the First Amended Master Long Form Complaint and/or any subsequent Short Form Complaints in which they are named as Defendants, and (2) the Master First Set of Interrogatories to All Defendants as described in CMO No. 3. This Order also provides for a process by which the dismissal of a party named in a Writ or Complaint but not named in a Short Form Complaint shall be effectuated. The Order sets forth the process for the filing of an affidavit of non-involvement. Finally, the Order supplements Case Management Order No. 3 by providing the Authorizations that must be attached to the Plaintiff Fact Sheet and discusses the procedure for the release of records.

In Re: Reglan Litigation-ORDER



II. PLAINTIFFS' FIRST AMENDED MASTER LONG FORM COMPLAINT

Pursuant to CMO No. 1, Plaintiffs filed a Master Long Form Complaint within thirty (30) days of entry of that order. Plaintiffs did not request service of the Master Long Form Complaint on the Defendants. Subsequently, Plaintiffs have filed a First Amended Master Long Form Complaint. CMO No. 1 and subsequent CMOs provide some deadlines that relate to the date of filing of the original Master Long Form Complaint and others that relate to the date when the original Master Long Form Complaint is served on the Defendants. Those deadlines in prior CMOs that relate to the date of filing of the original Master Long Form Complaint are hereby modified and will now relate to the date when the First Amended Master Long Form Complaint was docketed on April 23, 2010. Deadlines in prior CMOs that relate to the date of service of the original Master Long Form Complaint are hereby modified and will now relate to the date of service of the First Amended Master Long Form Complaint. All references in prior CMOs to the Master Long Form Complaint will hereinafter be understood to relate to the First Amended Master Long Form Complaint.

III. DEFENDANTS' RESPONSES TO THE FIRST AMENDED MASTER LONG FORM COMPLAINT

Parties named as Defendants in the First Amended Master Long Form Complaint shall respond to that pleading by filing and serving either:

- A. Preliminary Objections to the First Amended Master Long Form Complaint; or

B. A brief Master Answer that shall be accepted as constituting a denial of all allegations in the First Amended Master Long Form Complaint and will be deemed an assertion of all applicable defenses thereto. The filing of a Master Answer shall also constitute a denial of all allegations asserted in any and all Short Form Complaints served on a Defendant in this litigation and an assertion of all applicable defenses thereto, regardless of whether a given Short Form Complaint is served before or after the date of a Defendant's Master Answer. That said, the filing of a Master Answer will not waive a Defendant's right, under CMO No. 1, to file Preliminary Objections to a Short Form Complaint.

IV. DEFENDANTS' RESPONSES TO SHORT FORM COMPLAINTS

Parties named as Defendants in Short Form Complaints shall respond to that pleading by filing and serving either:

A. Preliminary Objections, provided that, in accordance with CMO No. 1, such Preliminary Objections could not be asserted in Preliminary Objections to the First Amended Master Long Form Complaint; or

B. A notice of appearance that shall constitute a denial of all allegations asserted in the Short Form Complaint and an assertion of all applicable defenses thereto. In accordance with CMO No. 1, if not already completed, a Defendant must file an entry of appearance on an individual case's docket. The reservation of any and all cross claims and the date for formally asserting any such claims that may be asserted on a case by case basis will be discussed in a subsequent CMO.

V. TIME TO RESPOND TO THE FIRST AMENDED MASTER LONG FORM COMPLAINT

A party named as a Defendant in the First Amended Master Long Form Complaint shall serve its response to the First Amended Master Long Form Complaint (as described in Section III, *supra*), only if it has been properly served with both a copy of the First Amended Master Long Form Complaint and at least one Short Form Complaint in which it is named a Defendant in an individual case. The Defendant's deadline to file such a response to the First Amended Master Long Form Complaint shall be the later of:

- A. 20 days after the first available day on which the Defendant has been served with both the First Amended Master Long Form Complaint and a Short Form Complaint; or
- B. 20 days after the date of execution of this Order.

VI. TIME TO RESPOND TO SHORT FORM COMPLAINTS

A. A party who has been named as a Defendant in both the First Amended Master Long Form Complaint and a Short Form Complaint shall serve its response to that Short Form Complaint in an individual case (as described in Section IV, *supra*), twenty (20) days after the later of:

- 1. The first available date on which it has been served with both the First Amended Master Long Form Complaint and the Short Form Complaint for the particular case; or

2. The date of execution of this Order.

B. A party who is not named as a Defendant in the First Amended Master Long Form Complaint but is named as a Defendant in a Short Form Complaint in an individual case shall serve its response to that Short Form Complaint within twenty (20) days of:

1. Service of the Short Form Complaint; or

2. The date of execution of this Order,

whichever is later, provided that, for purposes of notice and due process, the party is also served with a copy of the First Amended Master Long Form Complaint. Similarly, a party who is not named as a Defendant in the First Amended Master Long Form Complaint, but only in a Short Form Complaint, shall also serve a response to the First Amended Master Long Form Complaint (as described in Section III, *supra*) under the same deadlines described in this section.

C. For avoidance of doubt, Plaintiffs' Liaison Counsel need only serve the First Amended Master Long Form Complaint once on each party named as a Defendant in the Reglan[®]/metoclopramide Litigation.

VII. CONSENT OF DISMISSAL OF PARTIES NOT NAMED AS DEFENDANTS IN SHORT FORM COMPLAINTS

A. Within ten (10) days after filing a Short Form Complaint, or other subsequent pleading such as an Amended Short Form Complaint, naming fewer than all Defendants named in any associated Complaint or Writ of Summons, the subject Plaintiff shall file a praecipe of discontinuance without prejudice as to all Defendants not named in the subsequent pleading. With respect to all Short Form Complaints filed before this Order is executed, the ten (10) days shall run from the date of execution of the Order, rather

than from the filing date of the Short Form Complaint. All Defendants named in the associated Complaint or Writ of Summons are deemed to consent to such discontinuance without prejudice as to all Defendants in the action not named in a subsequent pleading. That said, all remaining Defendants reserve their right to seek contribution.

B. In the event that a Plaintiff fails to file the praecipe of discontinuance as contemplated by paragraph A, any other party to the case may send a letter to Plaintiff's counsel, with a copy to all parties, requesting that the praecipe of discontinuance be filed. Absent written objection served on all parties to the case by Plaintiff within ten (10) days of service of the letter, any Defendant may file the praecipe of discontinuance, to which all parties will be deemed to have consented.

VIII. AFFIDAVIT IN LIEU OF RESPONSE TO PLAINTIFFS' INTERROGATORIES

In lieu of responding to Master First Set of Interrogatories, a Defendant may serve an Affidavit attesting to the fact that neither the named defendant nor any current or former corporate subsidiary of the defendant manufactured, sold, distributed or marketed Reglan[®]/metoclopramide at any time. Upon service of the affidavit, the attesting defendant's discovery obligations are suspended. If Plaintiffs believe that there is a good faith basis for requiring the attesting defendant to respond to said interrogatories, the parties agree to meet and confer. If they are unable to resolve the issue, the dispute will be submitted to Discovery Master Bock who may require defendant to respond to the interrogatories or may fashion such other relief as he may deem appropriate. Nothing in this Paragraph shall constitute a waiver by Plaintiffs of any of their rights with respect to the attesting defendant.

IX. AUTHORIZATIONS AND PROCEDURE FOR RELEASE OF RECORDS

In accordance with the timing set forth in Case Management Order No. 3, completed Plaintiff Fact Sheets shall be accompanied by executed copies of the Authorizations that are attached hereto as Exhibit "A." Defendant shall provide via electronic mail to Plaintiffs' individual counsel all completed authorizations for records, and Plaintiffs' individual counsel shall have five (5) business days to object to the use of the authorizations in writing. Authorizations shall not be utilized over objection until resolution by meet & confer or a ruling by the Special Discovery Master.

Prior to providing psychological, psychiatric, mental health, counseling and/or insurance records to Defendants, MCS will notify Plaintiffs' counsel that such records are in the possession of MCS. Plaintiff's counsel shall have thirty (30) days to review and make redactions prior to production to Defendants. On the thirty-first day, absent objection, the records will be made available to all parties. With respect to any redacted materials, Plaintiffs shall identify the record provider and basis for redaction to all parties of record within five (5) days of counsel's direction to redact. Upon objection by defense counsel, Defendants may seek the redacted information through the meet and confer or Special Discovery Master processes.

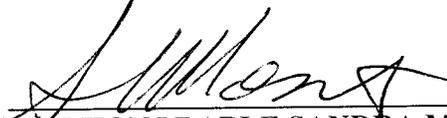
X. AUTHORIZATIONS AND TAX RECORDS

Tax records will be provided only in cases where a Plaintiff is claiming loss of earnings.

Date:

6/14/10

SO ORDERED



THE HONORABLE SANDRA MAZER MOSS

EXHIBIT A

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip Code: _____

I. General Release.

I hereby authorize _____ to disclose the information set
[Name and address of record source: e.g., Employer

forth in Section IV of this Authorization for the period from _____, _____ to _____, _____.

The released information is required for litigation. I further authorize The MCS Group, Inc., a private record reproduction company, upon presentation of this authorization or a copy thereof, to photocopy such records as are reasonably necessary for the above-state purposes.

II. HIPAA Complaint Authorization for the Release of Medical Records Pursuant to 45 CFR 164.508. I authorize the disclosure of all protected medical information for the purpose of review and evaluation in connection with a legal matter. I expressly request that the designated records custodian of all covered entities under HIPAA disclose full and complete protected medical information: _____

[Name of the Provider: Hospital, Doctor, Insurance Co.]

a.) Person(s) authorized to disclose the information:

b.) Information to be disclosed: I understand that any information disclosed in response to this request will include any information related to AIDS/HIV, sexually transmitted diseases, psychiatric/psychological care, treatment for drug and alcohol abuse and genetic testing **unless** specifically checked below.

- | | |
|--|---|
| <input type="checkbox"/> AIDS/HIV Communicable Disease Information | <input type="checkbox"/> Sexually transmitted disease(s), diagnosis and/or testing |
| <input type="checkbox"/> Psychiatric/Psychological Care | <input type="checkbox"/> Treatment for Drug/ Alcohol Abuse <input type="checkbox"/> Genetic testing |

c.) Person(s) authorized to receive the disclosed information: The MCS Group, Inc. on behalf of: _____
[Name of MCS Client]

I further authorize The MCS Group, Inc., a private record reproduction company, upon presentation of this authorization or a copy thereof, to photocopy such records as are reasonably necessary for the above-state purposes.

d.) Purpose of this request: At my request.

e.) Expiration Date: Unless otherwise revoked, this authorization will expire two years after the date of this authorization or later as indicated here _____.

f.) Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying in writing each Person identified in Section (a). I understand that the revocation is only effective after it is received and logged by such Person. I understand that any disclosure made prior to the revocation under this authorization will not be affected by the revocation.

g.) Subsequent Disclosure: I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

h.) Impact on Medical Treatment: I understand that I do not need to sign this authorization to assure any medical treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer for each Person identified in Section (a).

i.) Redisclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information, may not apply to the recipient of the information and therefore may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure.

j.) Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

III. Signature/Certification.

Signature of Person Identified Above or his or her Authorized Representative / Guardian

Date

By signing this authorization, the Authorized Representative and/or Guardian warrants that he or she has the authority to act on behalf of the person identified above on the basis of: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

IV. Information Subject to the General Release.	
Provider <input type="checkbox"/>	Employment: Copies of any and all records including but not limited to all applications for employment, all prior employment verification information, all pre-employment background or health documentation, applications for insurance, insurance forms, all physician or medical reports or records of any kind pertaining to physical examination required for employment, continued employment, or health or disability insurance, all reports or records of job or other injury, attendance records, sick time records, vacation records, payroll records, W-2 forms, salary history, progress records, letters of complaint, layoffs or termination for any and all times, occasions or reasons, pertaining to the Person identified on the front of this Authorization Form.
<input type="checkbox"/>	Social Security Benefits: Any and all records showing all payments and benefits received, and all benefits still available and not used by the Person identified on the front of this Authorization Form, including but not limited to any and all disability benefits, application for benefits, approval or denial of benefits and other social security benefits records regarding the above mentioned individual.
<input type="checkbox"/>	School: Copies of any and all school records, transcripts, attendance records, disciplinary reports, extracurricular activities, and cumulative records regarding the Person identified on the front of this Authorization Form.
<input type="checkbox"/>	Other:
V. Information Subject to the Health Information Release.	
Provider <input type="checkbox"/>	Employment: Copies of any and all records including but not limited to all applications for employment, all prior employment verification information, all pre-employment background or health documentation, applications for insurance, insurance forms, all physician or medical reports or records of any kind pertaining to physical examination required for employment, continued employment, or health or disability insurance, all reports or records of job or other injury, attendance records, sick time records, vacation records, payroll records, W-2 forms, salary history, progress records, letters of complaint, layoffs or termination for any and all times, occasions or reasons, pertaining to the Person identified on the front of this Authorization Form.
<input type="checkbox"/>	Pharmacy: Any and all prescription records kept in the regular course of business including but not limited to prescription prescribed, physicians prescribing medications, medication description, medication side effect print out, frequency medication being taken, billing, insurance and payment records, etc., and any and all records kept in your file regarding the below listed party; from the first date of treatment to the present (pertaining to the Person identified on the front of this Authorization Form).
<input type="checkbox"/>	Medical Insurance: Copies of any and all claim files concerning claims made by the below listed party including but not limited to pay out sheets, medical records, bills and reports of treating and examining physicians, state of claims, correspondence, notes and documents concerning any payments made to medical providers under the provisions of the policy. Insured: (the Person identified on the front of this Authorization Form).
<input type="checkbox"/>	Medical: Copies of any and all medical records, reports, charts, notes, diagrams, documents, papers, correspondence, memoranda, microfilmed document emergency room reports, billing information, x-ray films, MRI films, and/or films or of radiological studies and any and all other records of reports in your possession, custody or control, from the inception of your records to the present pertaining to the Person identified on the front of this Authorization Form.
<input type="checkbox"/>	Other:

The Authorization for Release of Information is subject to the requirements of Case Management Order Nos. 3 and 8 in the matter of *In Re: Reglan®/metoclopramide Litigation*, Philadelphia Court of Common Pleas No. 1001-01997.

**Information to Help You Fill Out the
“1-800-MEDICARE Authorization to Disclose Personal Health Information” Form**

By law, Medicare must have your written permission (an “authorization”) to use or give out your personal medical information for any purpose that isn't set out in the privacy notice contained in the Medicare & You handbook. You may take back (“revoke”) your written permission at any time, except if Medicare has already acted based on your permission.

If you want 1-800-MEDICARE to give your personal health information to someone other than you, you need to let Medicare know in writing.

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information. (For example: Executor/Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.) Also, please explain your relationship to the beneficiary.

Please use this step by step instruction sheet when completing your “1-800-MEDICARE Authorization to Disclose Personal Health Information” Form. Be sure to complete all sections of the form to ensure timely processing.

1. Print the name of the person with Medicare.

Print the Medicare number exactly as it is shown on the red, white, and blue Medicare card, including any letters (for example, 123456789A).

Print the birthday in month, day, and year (mm/dd/yyyy) of the person with Medicare.

2. This section tells Medicare what personal health information to give out. Please check a box in 2a to indicate how much information Medicare can disclose. If you only want Medicare to give out limited information (for example, Medicare eligibility), also check the box(es) in 2b that apply to the type of information you want Medicare to give out.

3. This section tells Medicare when to start and/or when to stop giving out your personal health information. Check the box that applies and fill in dates, if necessary.

4. Medicare will give your personal health information to the person(s) or organization(s) you fill in here. You may fill in more than one person or organization. If you designate an organization, you must also identify one or more individuals in that organization to whom Medicare may disclose your personal health information.

5. The person with Medicare or personal representative must sign their name, fill in the date, and provide the phone number and address of the person with Medicare.

If you are a personal representative of the person with Medicare, check the box, provide your address and phone number, and attach a copy of the paperwork that shows you can act for that person (for example, Power of Attorney).

6. Send your completed, signed authorization to Medicare at the address shown here on your authorization form.
7. If you change your mind and don't want Medicare to give out your personal health information, write to the address shown under number six on the authorization form and tell Medicare. Your letter will revoke your authorization and Medicare will no longer give out your personal health information (except for the personal health information Medicare has already given out based on your permission).

You should make a copy of your signed authorization for your records before mailing it to Medicare.

1-800-MEDICARE Authorization to Disclose Personal Health Information

Use this form if you want 1-800-MEDICARE to give your personal health information to someone other than you.

1. **Print Name** _____ **Medicare Number** _____ **Date of Birth** _____
(First and last name of the person with Medicare) (Exactly as shown on the Medicare Card) (mm/dd/yyyy)

2. Medicare will only disclose the personal health information you want disclosed.

2A: Check only one box below to tell Medicare the specific personal health information you want disclosed:

- Limited Information (go to question 2b)
- Any Information (go to question 3)

2B: Complete only if you selected “limited information”. Check all that apply:

- Information about your Medicare eligibility
- Information about your Medicare claims
- Information about plan enrollment (e.g. drug or MA Plan)
- Information about premium payments
- Other Specific Information (please write below; for example, payment information)

3. **Check only one box below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

- Disclose my personal health information indefinitely
 - Disclose my personal health information for a specified period only
beginning: (mm/dd/yyyy) _____ and ending: (mm/dd/yyyy) _____
-

4. Fill in the name and address of the person(s) or organization(s) to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:

1. Name: _____

Address: _____

2. Name: _____

Address: _____

3. Name: _____

Address: _____

5. I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.

Signature

Telephone Number

Date (mm/dd/yyyy)

Print the address of the person with Medicare (Street Address, City, State, and ZIP)

Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person with Medicare signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP)

Telephone Number of Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

6. Send the completed, signed authorization to:

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

7. Note:

You have the right to take back (“revoke”) your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above.

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0930**. The time required to complete this information collection is estimated to average **15 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Social Security Administration
Consent for Release of Information

Please read these instructions carefully before completing this form.

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

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

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

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

How to Complete This Form

This consent form must be completed and signed only by:

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

To complete this form:

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

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

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number
------	---------------	------------------------

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

NAME	ADDRESS
_____	_____
_____	_____
_____	_____

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

- ___ Social Security Number
- ___ Identifying information (includes date and place of birth, parents' names)
- ___ Monthly Social Security benefit amount
- ___ Monthly Supplemental Security Income payment amount
- ___ Information about benefits/payments I received from _____ to _____
- ___ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
- ___ Medical records
- ___ Record(s) from my file (specify) _____
- ___ Other (specify) _____

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

Signature: _____

(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. Certified/Non-Certified Detailed Earnings Information

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

OR

2. Certified Yearly Totals of Earnings

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

DO NOT USE THIS FORM FOR:

Non-certified yearly totals of earnings

This service is free to the public.

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

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

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 11 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. *Send only comments relating to our time estimate to this address, not the completed form.*

INFORMATION ABOUT YOUR REQUEST

How Do I Get This Information?

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

Can I Get This Information For Someone Else?

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

Who Can Sign On Behalf Of The Individual?

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

Is There A Fee For This Information?

1. Certified/Non-Certified Detailed Earnings Information

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

Sometimes, there is no charge for detailed information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us

and it does not agree with your records), we will supply you with more detail for the period in question. Occasionally, earnings amounts are wrong because an employer did not correctly report earnings or earnings are credited to the wrong person. In situations like these, we will send you detailed information, at no charge, so we can correct your record.

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

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

2. Certified Yearly Total of Earnings

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

3. Method of Payment

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

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

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

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

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

2. What kind of information do you need?

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

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

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

Do you want us to certify the information? Yes No
If yes, enter \$15.00 B. \$ _____

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

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

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

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

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

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

Name _____ Address _____
City, State & Zip Code _____

6. Mail Completed Form(s) To:

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

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

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

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

How Much Do I Have to Pay For Detailed Earnings?

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

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

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

• **Whose Earnings Can Be Requested**

1. Your Earnings

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

2. Someone Else's Earnings

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

3. A Deceased Person's Earnings

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

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

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

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

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

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

Exception:

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

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

Note: Please read Paperwork/Privacy Act Notice

CHECK ONE _____	<input type="checkbox"/> Visa <input type="checkbox"/> American Express <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> Diners Card
Credit Card Holder's Name _____ (Enter the name from the credit card)	_____ First Name, Middle Initial, Last Name
Credit Card Holder's Address _____	_____ Number & Street
	_____ City, State, & Zip Code
Daytime Telephone Number _____	_____ Area Code Telephone Number
Credit Card Number _____	____ - ____ - ____ - ____
Credit Card Expiration Date _____	____ / ____ Month Year
Amount Charged _____	\$ _____
Credit Card Holder's Signature _____	

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

PRIVACY ACT NOTICE

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

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

QUESTIONNAIRE ABOUT MILITARY SERVICE

1. WHY WE ARE SENDING YOU THIS FORM: We are unable to locate a record with the information provided in your original inquiry **OR** the record needed to answer your inquiry was lost in the July 1973 fire that destroyed millions of records at the National Personnel Records Center. The records stored in the area which suffered the most damage in the fire were those of Army veterans discharged or deceased between November 1, 1912, and December 31, 1959, **AND** Air Force veterans discharged, deceased, or retired before January 1, 1964, whose names come alphabetically after Hubbard, James E.

The information you provide on page 2 of this form may help locate the record, if it is available; or, if the record is not available, it may enable the Center to make use of various alternate sources to reconstruct some of the basic service record data. Please note that if the *only* document you need is the Report of Separation (DD Form 214, WDAGO Form 53-55, etc.), it may be available from a former employer or from the recorder's office of the city or county where the veteran lived just after separation/discharge.

2. WHAT YOU NEED TO DO:

- ☞ Fill out page 2 of this form (NA Form 13075) as completely as possible, as well as any other form(s) you may have received with this one, such as Standard Form (SF) 180 and NA Form 13055;
- ☞ Attach copies of any papers you have that relate to the requested military service, such as military orders, award citations, and military addresses as shown on letters mailed home; and
- ☞ Send the above item(s) to the National Personnel Records Center at the address shown below or fax to (314) 801-9195. If we do not receive this information from you within 30 days, your request will be closed without further reply.

3. FEE FOR ARCHIVAL RECORDS: A fee is often required for copies of documents from an archival record. An archival record is one that was transferred to the legal custody of the National Archives and Records Administration (NARA) 62 years after the subject of the record was discharged or retired, or died in service. Archival records are open to the public. Access to archival records does not require written authorization from the veteran or next-of-kin. You will be notified if there is a charge associated with information from the record you are requesting.

4. MEDALS INFORMATION: Are you requesting military service medals only? If so, do you have a copy of the Report of Separation (DD Form 214, WDAGO Form 53-55, etc.) and other military papers that show which medals were earned? If you send such information about medals, you do not need to fill out this NA Form 13075; however, you must return page 2 (with the barcode) so that we can locate your original request. Finally, if possible, please send a list of the names and locations of all military units or "outfits" to which the veteran was assigned, including dates, while on active duty. This may help determine eligibility for "unit" awards.

Special provisions when a record is archival: Only requests from veterans for replacements of awards will be processed without a fee. All other requesters will be given the opportunity to purchase copies of available archival records in the custody of the National Archives and Records Administration (NARA). We will not verify entitlement to medals, provide specific documents, or extract awards information for anyone other than the veteran when the record is archival.

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

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

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. The information requested on this form is being collected and used by the National Personnel Records Center to identify and locate military service records that could not be identified and located in response to the original inquiry. Public burden reporting for this collection of information is estimated to be five minutes per response, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (NHP), 8601 Adelphi Road, College Park, MD 20740-6001. **DO NOT SEND COMPLETED FORMS TO THIS ADDRESS. SEND COMPLETED FORMS TO THE ADDRESS BELOW.**

Date

Prepared by
NRPM _____

NATIONAL PERSONNEL RECORDS CENTER
(Military Personnel Records)
9700 Page Avenue
St. Louis, MO 63132-5100

QUESTIONNAIRE ABOUT MILITARY SERVICE

Please complete this form to the best of your ability.

Name(s) used during service (and nicknames, if any):			Branch of Service:		
Last	First	Middle	<input type="checkbox"/> Army	<input type="checkbox"/> Air Force	<input type="checkbox"/> Navy
			<input type="checkbox"/> Marine Corps	<input type="checkbox"/> Coast Guard	

Veteran's Social Security Number:	Date of Birth:	City and State (Country) of Birth:
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Served as:	Serial/Service number(s):	Home Address:			
<input type="checkbox"/> Officer		When entered service: _____			
<input type="checkbox"/> Enlisted		City	County	State	
If enlisted:	<input type="checkbox"/> volunteered <input type="checkbox"/> drafted	When released from active duty: _____			
Final Rank:		City	County	State	

Was service six months active duty for training only?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Selective Service:	Local Board Number	City	State	Veteran's Selective Service Number
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Names of close relatives when military service began (parents, siblings, spouse, children): _____

Place of enlistment or induction (where veteran took oath of service, such as examining station, reception center, or place of basic training.) Show name of military facility, city, state:	Month/Day/Year began active duty:
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Place of basic training and month/day/year began (if different from place and date shown on line above): _____

Type of military assignment (infantry, airborne, engineer, bombers, fighters, supply, maintenance, food service, etc.): _____

Last military organization and location (show full unit designations, such as army, division, regiment, battalion, company): _____

Separation Station (if this service member was released at a separation station after leaving the last "permanent" organization or "unit", include location of separation station):	Month/Day/Year released from active duty:
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Month/Day/Year of any reenlistment(s) (include full designation and location of unit to which assigned at that time):	If this veteran is deceased, show date of death:
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Did the veteran ever:

a. File a claim for VA benefits?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	If yes, show VA Claim Number: _____
b. Serve in the Reserves after release from active duty period shown above?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	If yes, show branch of service _____ show mo/yr from _____ to _____
c. Receive a state bonus for military service?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	If yes, show state _____ mo/yr paid _____
d. Serve in the National Guard?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	If yes, show state _____ <input type="checkbox"/> Army <input type="checkbox"/> Air show mo/day/yr from _____ to _____
e. Retire from any military service branch?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	If yes, show branch of service _____ show mo/yr retired _____
f. Spend time on the Temporary Disability Retired List (TDRL)?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	If yes, show branch of service _____ show mo/day/yr from _____ to _____
g. Serve active duty in any other military service branch in later years?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	If yes, show branch of service _____ show mo/day/yr from _____ to _____
h. Work for the Federal Government as a civilian?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	If yes, show agency name _____ show city/state _____ show mo/day/yr from _____ to _____

Purpose: (Optional – An explanation of the purpose of this request is strictly voluntary. Such information may help the National Personnel Records Center to provide the best possible response and will in no way be used to make a decision to deny the request.)

SIGNATURE:	TODAY'S DATE:	DAYTIME PHONE NUMBER: ()
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Before you send this form, please make sure you have followed the instructions in the "What You Need To Do" section on the other side; otherwise it may not be possible to service this request.

**AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS
AND COMPLETE FILE**

RE: Company name

Name:

Address:

Date of Birth:

I hereby authorize and permit any person or entity to release for inspection and copying to counsel for defendants in the above-referenced litigation, or their authorized representatives, all of my employment records including but not limited to complete personnel file and records and documents relating to dates of my employment with _____ this includes the true and complete copy of my personnel file which includes job description, responsibilities, supervisors, my absences, dates of employment, evaluations, any disciplinary actions and any medical or accident-related injuries that occurred while employed by _____. This authorization is valid only during the pendency of the litigation.

In addition, you are hereby authorized to accept an original, photostatic or faxed copy of this authorization to be a true and correct authentic copy thereof.

Signature of Plaintiff

Print Name of Plaintiff

Dated this

_____ day of _____, 2010



Return to: Walgreens Custodian of Records Department, 1901 East Voorhees Street, PO Box 4039, MS #735, Danville, Illinois 61834

All sections must be filled in completely or the authorization is NOT valid!!

AUTHORIZATION - RELEASE OF INFORMATION REQUESTED BY PATIENT

Your Name: _____
Date of Birth: _____
Street Address: _____
City, State, Zip: _____
Telephone Number: _____

Person/organization (or class of persons) you are authorizing Walgreens to release your information to:

Name: _____
Address: _____
City, State, Zip: _____

Describe or list the information that you are asking us to release:

List the specific purpose for requesting this information:

Expiration Date [Must include a date or specific time frame!]:

This authorization expires [specify date or event] one year from date signed

Information regarding this Authorization:

- You have the right to revoke this Authorization, in writing to Walgreens Custodian of Records Department, at any time. The revocation is only effective after it is received and logged by Walgreens. Any use or disclosure made prior to a revocation is not included as part of the revocation.
- Refer to our Notice of Privacy Practices for permitted uses and disclosures of protected health information ("PHI"). You may obtain a copy of this Notice from the Privacy Office or on www.walgreens.com. Please keep a copy of this authorization for your records.
- Once PHI is disclosed to others, it may be redisclosed by them to persons or entities that are not subject to the privacy regulations, which means that the PHI may no longer be protected by regulations.
- Privacy regulations prohibit the conditioning of treatment, payment, enrollment, or eligibility for benefits on signing this Authorization.
- This Authorization must be signed and dated by the patient or signed and dated by the patient's personal representative and include a description of that person's ability to act on behalf of the patient.

Signature:

I, _____, by signing below, authorize Walgreens to use or disclose my protected health information as described above.

Signature _____ Date _____

If this Authorization is signed by the patient's personal representative, please explain your authority to act and provide legal documentation:

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. ▶ _____

Note. If the copies must be certified for court or administrative proceedings, check here

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

_____	_____	_____	_____
_____	_____	_____	_____

8 Fee. There is a \$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	
c Total cost. Multiply line 8a by line 8b	\$

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

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

General Instructions

Section references are to the Internal Revenue Code.

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

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

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

Automated transcript request. You can call 1-800-829-1040 to order a transcript through the automated self-help system. Follow prompts for "questions about your tax account" to order a tax return transcript.

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

If you are requesting a return for more than one year and the chart below shows two different RAVS teams, send your request to the team based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to the "Internal Revenue Service" at:
Florida, Georgia, North Carolina, South Carolina	RAIVS Team P.O. Box 47-421 Stop 91 Doraville, GA 30362
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, or A.P.O. or F.P.O. address	RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	RAIVS Team Stop 37106 Fresno, CA 93888
Arkansas, Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia	RAIVS Team Stop 6705 P-6 Kansas City, MO 64999

Chart for all other returns

If you lived in or your business was in:

Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Utah, Washington, Wyoming, a foreign country, or A.P.O. or F.P.O. address

Mail to the "Internal Revenue Service" at:

RAIVS Team
P.O. Box 9941
Mail Stop 6734
Ogden, UT 84409

Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia, Wisconsin

RAIVS Team
P.O. Box 145500
Stop 2800 F
Cincinnati, OH 45250

Specific Instructions

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

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the return be sent to a third party, the IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected.

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

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

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

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

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

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

Privacy Act and Paperwork Reduction Act Notice.

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

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

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

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

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224. Do not send the form to this address. Instead, see *Where to file* on this page.