

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

ENTERED

JAN - 7 2003

SAMUEL L. KAY, CLERK
U. S. District & Bankruptcy Courts
Southern District of West Virginia

IN RE: SERZONE PRODUCTS : MDL No. 1477
LIABILITY LITIGATION : (Judge Goodwin)
: :
This Document Relates To All Cases : Discovery Order No. 5
: :

PLAINTIFFS' FACT SHEETS

Having considered the submissions of the parties, and the comments and proposals presented to the Court, it is hereby **ORDERED** that:

1. Plaintiff's Fact Sheet

The parties have agreed upon a Plaintiff's Fact Sheet (Exhibit A) ["PFS"], an Authorization for Release of Medical Records (Exhibit B), an Authorization for Release of Employment and Unemployment Records (Exhibit C), an Authorization for Release of Education Records (Exhibit D), and an Authorization for Release of Workers' Compensation, Social Security and other Disability Records (Exhibit E) [collectively the "Authorizations"]. The PFS and Authorizations will be completed by each plaintiff pursuant to the terms of this Order. Each plaintiff's responses in the PFS shall be verified under oath and treated as answers to interrogatories and requests for the production of documents, pursuant to Federal Rules of Civil Procedure 33 and 34. Each plaintiff shall supplement his/her responses in accordance with Federal Rule of Civil Procedure 26.

2. Initial Wave Due Date

Each plaintiff whose case was filed before August 12, 2002, shall have until March 7, 2003 to complete and serve a PFS, and the Authorizations and documents

required therein, on Defendant's Liaison Counsel in accordance with the terms of this Order.

Each plaintiff whose case was filed after August 12, 2002, and before the date of this Order, shall have sixty (60) days from the date of this Order to complete and serve a PFS, and the Authorizations and documents required therein, on Defendant's Liaison Counsel in accordance with the terms of this Order.

3. Later Filed Cases Due Dates

Each plaintiff whose case was filed after the date of this Order shall have sixty (60) days from the date the PFS and Authorizations are served on his/her counsel (or such plaintiff, if unrepresented) to complete and serve the PFS, and the Authorizations and documents required therein, on Defendant's Liaison Counsel in accordance with the terms of this Order.

4. Service

With respect to those cases governed by Paragraph 3 of this Order, Defendant's Liaison Counsel shall serve the PFS and Authorizations, along with a copy of this Order, on counsel representing plaintiff(s) (or plaintiff, if unrepresented) within five (5) days of the docketing of a case in this MDL by mail or by delivery service. A copy of each cover letter serving a PFS and Authorizations shall also be forwarded to Plaintiffs' Liaison Counsel.

Each plaintiff shall serve his/her completed PFS, executed Authorizations, and documents required therein, in accordance with the terms of this Order, directly on Defendant's Liaison Counsel by mail or by delivery service:

If Mailed:

Michael B. Victorson, Esq.
Jackson Kelly PLLC
Post Office Box 553
Charleston, West Virginia 25322

If Delivery Service is Used:

Michael B. Victorson
Jackson Kelly PLLC
1600 Laidley Tower
Charleston, West Virginia 25301

Each plaintiff shall, likewise, serve a copy of his/her PFS, executed Authorizations, and documents required therein, upon Plaintiff's Liaison Counsel by mail or by delivery service:

Carl N. Frankovitch, Esq.
Frankovitch, Anetakis, Colantonio & Simon
337 Penco Road
Weirton, West Virginia 26062-3828

5. Responsive Documents

If neither a particular plaintiff nor that plaintiff's counsel possesses documents responsive to the requests contained in Section IX of the PFS, at the time the completed PFS is served, that plaintiff's counsel (or that plaintiff, if unrepresented) must inform Defendant's Liaison Counsel [Michael B. Victorson, Esq.] of such in writing by letter via mail, e-mail or facsimile, a copy of which shall be delivered to Plaintiffs' Liaison Counsel.

6. Record Copy Service

The defendant has retained [COMPANY NAME], a national medical record copy service, to collect and copy each plaintiff's medical, employment and other records. Although it is contemplated that [COMPANY NAME] will generally be responsible for collecting each plaintiff's records, there may be times when, due to concerns for

expediency, the defendant will itself endeavor to collect certain records. In those instances: (A) the defendant will provide notice of the use of authorizations as required by paragraph 7 herein; and (B) any timely objection should be served via e-mail or facsimile on Plaintiffs' Liaison Counsel and Defendant's Liaison Counsel, as required by paragraph 8. Additionally, the defendant will stamp all records "Confidential, Subject to Protective Order," in accordance with paragraph 10. Each plaintiff shall be entitled to receive, upon request, a complete list, and to inspect and obtain copies, of all records collected directly by the defendant, at a reasonable cost.

7. Notice of Use of Authorizations

[COMPANY NAME] shall provide each plaintiff's counsel (or each plaintiff, if unrepresented) ten (10) days advance notice of its intention to use an authorization to collect records from any health care provider, employer or other source beyond those identified in a plaintiff's PFS (including any subsequent supplements thereto) or by a plaintiff at his/her deposition. Such notice shall be via e-mail or facsimile with a copy to Defendant's Liaison Counsel. For those health care providers, employers and other sources of information identified in a plaintiff's PFS or by a plaintiff at his/her deposition, such plaintiff and his/her counsel waives any notice requirement, except as provided in paragraph 8(A).

8. Objections to Use of Authorizations

A. Should a plaintiff object to the collection of records from a health care provider, employer, or other source of information identified in his/her PFS (including any subsequent supplements thereof), or at his/her deposition, then such objection (in letter form) shall accompany that plaintiff's PFS upon service, or shall be

preserved on the record at such plaintiff's deposition, or otherwise shall be waived. If made at the time of the service of the PFS, the objection, in two (2) pages or less, shall identify the legal basis for the objection and describe the nature of the documents to which the objection is asserted in a manner that, without revealing the information protected, will enable the defendant to assess the applicability of the protection. If preserved at a plaintiff's deposition, within five (5) business days of that deposition, that plaintiff shall, in a form similar to that used when the objection accompanies the PFS, identify the legal basis for the objection and describe the nature of the documents to which the objection is asserted in a manner that, without revealing the information protected, will enable the defendant to assess the applicability of the protection. Any such objection will then be resolved pursuant to the procedure set forth in paragraph 9.

B. When a plaintiff receives notice from [COMPANY NAME] of its intention to use an authorization to collect medical, employment or other records from sources beyond those identified in his/her PFS (including any subsequent supplements thereof) or at his/her deposition, that plaintiff shall have five (5) business days from the date of notice to submit an objection (in letter form) to the use of the authorization. The objection, in two (2) pages or less, shall identify the legal basis for the objection and describe the nature of the documents to which the objection is asserted in a manner that, without revealing the information protected, will enable the defendant to assess the applicability of the protection. Copies of the objection shall be served, via e-mail or facsimile, on:

[COMPANY NAME]
[CONTACT NAME]
[E-MAIL ADDRESS]
[FAX NUMBER]

AND

If Mailed:

Michael B. Victorson, Esq.
Jackson Kelly PLLC
Post Office Box 553
Charleston, West Virginia 25322

If a Delivery Service is Used:

Michael B. Victorson
Jackson Kelly PLLC
1600 Laidley Tower
Charleston, West Virginia 25301

Or, if by E-Mail or Facsimile,

E-Mail: mvictorson@jacksonkelly.com
Fax: (304) 340-1050

AND

Carl N. Frankovitch, Esq.
Frankovitch, Anetakis, Colantonio & Simon
337 Penco Road
Weirton, West Virginia 26062-3828

E-Mail: carln@facslaw.com
Facsimile: (304) 723-5892

If no such objection is received within five (5) business days of notice, the records shall be requested and produced to the defendant.

9. Procedure for Resolution of Objections to Use of Authorizations

Upon receipt of a plaintiff's objection, no further effort will be made by the defendant (or its representative) to collect the records at issue until the objection is resolved. The parties shall have five (5) business days, from the date of a plaintiff's objection, to meet and confer to resolve the objection. Should the parties be unable to

resolve the objection, then such plaintiff's objection and a response by the defendant (in letter form) of two (2) pages or less, shall be submitted to the Magistrate Judge for resolution. The Magistrate Judge will rule on the objection. Any party wishing to appeal the ruling must follow the provisions of Federal Rule of Civil Procedure 72.

10. Confidentiality

Pursuant to Pretrial Order No. 2, all records regarding any plaintiff collected by [COMPANY NAME] through the use of the Authorizations ["Collected Records"] are hereby designated "CONFIDENTIAL." All Collected Records shall be stamped or otherwise marked by [COMPANY NAME] with the legend:

**CONFIDENTIAL
SUBJECT TO PROTECTIVE ORDER**

Disclosure of Collected Records shall be governed by the provisions of Pretrial Order No. 2.

11. Copies of Collected Records

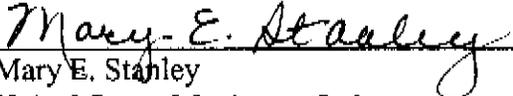
Each plaintiff shall be entitled to receive, upon request, a complete list, and to inspect and obtain copies, of all Collected Records pertaining to such plaintiff, directly from [COMPANY NAME], at a reasonable cost.

12. Extension of Discovery Deadlines

Nothing in this order shall be interpreted as a restriction upon the ability of: (a) the parties to stipulate to a reasonable extension of discovery deadlines in a particular case; or (b) a plaintiff or the defendant to move for an extension of discovery deadlines in a particular case based on a showing of good cause.

The Clerk is directed to send a copy of this Discovery Order # 5 to Plaintiffs' Liaison Counsel and to Defendant's Liaison Counsel.

ENTER: January 7, 2003


Mary E. Stanley
United States Magistrate Judge

680330

**IN RE SERZONE
PRODUCTS LIABILITY LITIGATION
MDL-1477**

PLAINTIFF'S FACT SHEET

Each plaintiff in MDL-1477 who has taken the antidepressant Serzone® must complete this Plaintiff's Fact Sheet, including all of the questions asked, the List of Medical Providers and Other Sources of Information, the request for the production of documents and the request for authorizations. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge.

INSTRUCTIONS

In completing this Fact Sheet it is expected that you will fully respond to each question and will provide all the information available to you that is sought by each question. The questions should be read broadly. If you do not know the answer to any question, please state that you do not know the answer. If any question is not applicable to you and your case, please state that it is not applicable. To the extent you cannot completely answer any question, please provide whatever information is available to you and, as to any information sought by the question which you do not know, please identify what part of the question you cannot answer. You may consult with your attorney if you have any questions regarding the completion of these forms.

If you are completing these forms for someone who took the antidepressant Serzone® who has died or cannot complete them him/herself, please answer as completely as you can for that person.

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

DEFINITIONS

In answering the questions set forth in this Fact Sheet, with the exception of the terms and phrases defined below, each term and phrase should be given their usual meaning.

The term "**injury**" shall mean any physical, emotional or psychological condition which it is alleged was caused or may be caused in the future by your use of Serzone®.

The phrase "**liver condition**" shall mean any failure, dysfunction, disease or abnormality of the liver, including, but not limited to, cirrhosis, hepatitis, necrosis, fibrosis, encephalopathy, inflammation or scarring of the liver.

The phrase "**liver function testing**" shall mean any examination, test, or procedure in which blood is drawn and analyzed to determine the level of liver enzymes or to evaluate the manner in which the liver is functioning.

4. In what capacity are you representing the individual:

5. If you were appointed by a court, state the:

Court	Date of Appointment
-------	---------------------

6. Your relationship to deceased or represented person:

7. If you represent a decedent's estate, state the date of death of the decedent.

[If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who took Serzone®. Those questions using the term "You" refer to the person who took Serzone®. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.]

C. Claim Information

1. Do you claim that you have suffered a physical injury as the result of Serzone® use?

Yes _____ No _____

2. If the answer to the foregoing question is "yes", state the nature of the physical injury or injuries which you claim.

3. Do you claim that you have suffered a psychological or emotional injury as the result of Serzone® use?

Yes _____ No _____

4. If the answer to the foregoing question is "yes", state the nature of the psychological or emotional injury or injuries which you claim.

5. If you do not claim to have suffered a physical, psychological or emotional injury as the result of Serzone® use, state how you have been injured or damaged.

II. PERSONAL INFORMATION

A. Last Name: _____

First Name: _____

Middle Name or Initial: _____

B. Maiden or other names used or by which you have been known, including the dates you used each name:

C. Address Information

1. Present Street Address:

Street Address City State Zip Code

2. List all other addresses where you have lived for the last fifteen (15) years:

Street Address City State Zip Code

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

D. Employment

1. _____
Name of Current or Last Employer

Name of Current or Last Supervisor or Superior

Current or Last Employer Address

Current or Last Employer Telephone Number

Dates of Current or Last Employment

Current or Last Occupation

2. Have you been unemployed for health reasons for 30 consecutive days or more within the last fifteen (15) years?

Yes _____ No _____

If so, please state the following for each period:

a. First and last date of period of unemployment: _____

b. Reason for unemployment: _____

c. With respect to any period of unemployment identified above, identify all unemployment benefits claimed and received for that period of unemployment:

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

E. Social Security, Visa or Green Card Number: _____

F. Date of Birth: _____

G. Place of Birth: _____

H. Are you a citizen of the United States?

Yes _____ No _____

I. Sex: Male _____ Female _____

J. Have you ever served in any branch of the U.S. Military?

Yes _____ No _____

If so, please state:

1. What branch and the dates of service. _____

2. Were you discharged for any reason relating to your health, physical or mental condition?

Yes _____ No _____

If yes, state what that condition was.

K. Have you ever been rejected from military service for any reason relating to your health, physical or mental condition?

Yes _____ No _____

If so, state what that condition was. _____

L. Have you filed a worker's compensation claim within the past 15 years ?

Yes _____ No _____

If so, please state the following for each claim filed:

1. Year claim was filed: _____
2. Where claim was filed: _____
3. Claim/docket number, if applicable: _____
4. Nature of disability: _____
5. Period of disability: _____
6. Attorney, if any, who represented you (name, address and telephone number):

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

M. Have you filed a social security disability claim within the past 15 years?

Yes _____ No _____

If so, please state the following for each claim filed:

1. Year claim was filed: _____
2. Where claim was filed: _____
3. Claim/docket number, if applicable: _____
4. Nature of disability: _____
5. Period of disability: _____

6. Attorney, if any, who represented you (name, address and telephone number):

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

N. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any physical, psychological or emotional injury?

Yes _____ No _____

If so, please state the following for each claim filed:

1. Year claim was filed: _____
2. Where claim was filed: _____
3. Claim/docket number, if applicable: _____
4. Nature of claim: _____
5. Attorney who represented you (name, address and telephone number):

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

O. Have you been convicted of or pled guilty to any crime ?

Yes _____ No _____

If so:

1. What was the offense? _____
2. What was the case number? _____
3. What was the date of conviction? _____
4. In what court was the conviction entered? _____

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

P. Education

Beginning with high school, complete the following information regarding educational institutions you have attended:

Name and Address of Educational Institution	Dates Attended	Degrees/Certifications Received

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

III. FAMILY INFORMATION

A. Are you currently married?

Yes _____ No _____

B. Date of marriage: _____

C. Has your spouse filed a loss of consortium claim in connection with this action?

Yes _____ No _____

D. 1. Spouse's name: _____

2. Spouse's date of birth: _____

3. Spouse's occupation: _____

4. Spouse's current address: _____

E. Have you had any prior marriages?

Yes _____ No _____

If so, for each marriage, state the following:

Prior Spouse's Name: _____

Prior Spouse's Last Known Address and Telephone Number: _____

Prior Spouse's Current Age: _____

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

F. Complete the following regarding your mother:

Mother's Name, Address and Telephone number:

Mother's Maiden Name: _____

Mother's Age (or Age at Death): _____

If Applicable, Cause of Death: _____

G. Complete the following regarding your father:

Father's Name, Address and Telephone Number:

Father's Age (or Age at Death): _____

If Applicable, Cause of Death: _____

H. Complete the following regarding your siblings, if any:

1. Sibling's Name, Address and Telephone Number:

Sibling's Age (or Age at Death): _____

If Applicable, Cause of Death: _____

2. Sibling's Name, Address and Telephone Number:

Sibling's Age (or Age at Death): _____
If Applicable, Cause of Death: _____

3. Sibling's Name, Address and Telephone Number:

Sibling's Age (or Age at Death): _____
If Applicable, Cause of Death: _____

4. Sibling's Name, Address and Telephone Number:

Sibling's Age (or Age at Death): _____
If Applicable, Cause of Death: _____

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

I. Do you have any children (whether by a current or prior marriage or relationship)?

Yes _____ No _____

If yes, state the number of children: _____

If so, for each child, state the following:

1. Child's Name, Address and Telephone Number:

Child's Age (or Age at Death): _____
Does this child currently reside with you? Yes _____ No _____

2. Child's Name, Address and Telephone Number:

Child's Age (or Age at Death): _____
Does this child currently reside with you? Yes _____ No _____

3. Child's Name, Address and Telephone Number:

Child's Age (or Age at Death): _____
Does this child currently reside with you? Yes _____ No _____

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

J. Has any parent, grandparent, sibling or child been diagnosed with any liver conditions?

Yes _____ No _____ I don't know _____

If yes, identify each such person below and provide the information requested.

1. Name, Address and Telephone Number:

Current Age (or Age at Death) _____
Diagnosis: _____
If Applicable, Cause of Death _____

2. Name, Address and Telephone Number:

Current Age (or Age at Death): _____
Diagnosis: _____
If Applicable, Cause of Death: _____

3. Name, Address and Telephone Number:

Current Age (or Age at Death): _____
Diagnosis: _____
If Applicable, Cause of Death: _____

IV. CONDITION FOR WHICH SERZONE® WAS PRESCRIBED

A. For what condition were you prescribed Serzone®?

B. Identify the healthcare provider(s) that prescribed Serzone® for you:

Name

Address

Telephone Number

- C. Did you receive relief from the symptoms for which Serzone® was first prescribed?

Yes _____ No _____ I don't know _____

If yes, please identify the benefits received and for how long you continued to take the medication: _____

If no, please state whether you continued to take the medication and, if so, why and for how long you continued to take the medication: _____

V. **DEPRESSION**

If you have been diagnosed with depression or any condition that led to your use of an antidepressant, answer the following:

- A. How old were you when you were first diagnosed with depression or any condition that led to your use of an antidepressant? _____
- B. State the exact diagnosis: _____
- C. By whom first diagnosed?

Name

Address

Telephone Number

D. Which of the following medications (or generic equivalents) have you used to treat your depression or any other condition that led to your use of an antidepressant? (If you do not know or do not recall, please indicate)

Medication	Yes	No	I Don't Know	Date First Taken/Dosage	Date Last Taken/Dosage
Selective Serotonin Reuptake Inhibitors (SSRIs):					
Fluoxetine hydrochloride (e.g. Prozac®)					
Sertaline hydrochloride (e.g. Zoloft®)					
Paroxetine hydrochloride (e.g. Paxil®)					
Tricyclic Anti-depressants (TCAs):					
Amitriptyline hydrochloride (e.g. Amitril®, Elavil®, Endep®, Emitrip®, Enovil®)					
Clomipramine (e.g. Anafranil®)					
Desipramine hydrochloride (e.g. Norpramin®, Pertofranc®)					
Doxepin hydrochloride (e.g. Adapin®, Sinequan®)					

Imipramine hydrochloride (e.g. Janimine®, SK-Pramine, Tipramine®, Tofranil®, Tofranil-PM®)					
Nortriptyline (e.g. Aventyl®, Pamelor®)					
Protriptyline hydrochloride (e.g. Vivactil®)					
Trimipramine maleate (e.g. Surmontil®)					
Heterocyclic Anti-depressants:					
Amoxapine (e.g. Asendin®)					
Trazodone hydrochloride (e.g. Dcsyrel®)					
Maprotiline hydrochloride (e.g. Ludiomil®)					
Monoamine Oxidase Inhibitors (e.g. MAOIs):					
Isocarboxazide (e.g. Marplan®)					
Phenelzine sulfate (e.g. Nardil®)					
Tranlycypromine sulfate (e.g. Parnate®)					
Other Anti-depressants:					

Bupropion hydrochloride (e.g. Wellbutrin®)					
Venlafaxine (e.g. Effexor®)					
Mirtazapine (e.g. Remeron®, Remeron®, SolTab®)					
Other Prescription Medications to Control Depression:					
Type:					

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

E. Have you taken any herbal treatments to control your depression or any other condition that led to your use of an antidepressant?

Yes _____ No _____ I don't know _____

If yes, state:

Type: _____
 Date First Taken: _____ Dosage: _____ mg _____ times per day
 Date Last Taken: _____ Dosage: _____ mg _____ times per day

F. Have you taken any other treatments, not previously listed, to control your depression or any other condition that led to your use of an antidepressant?

Yes _____ No _____ I don't know _____

If yes, state:

Type: _____
 Date First Taken: _____ Dosage: _____ mg _____ times per day
 Date Last Taken: _____ Dosage: _____ mg _____ times per day

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

G. Have you taken Serzone®?

Yes _____ No _____

If yes, state:

Date First Taken: _____ Dosage: _____ mg _____ times per day

Date Last Taken: _____ Dosage: _____ mg _____ times per day

H. If there was a change in dosage, what was your understanding of the reason for the change?

I. Were there any gaps in your Serzone® use?

Yes _____ No _____ I don't know _____

If yes, please explain: _____

J. When you were taking Serzone®, were you also taking any other medication(s)?

Yes _____ No _____ I don't know _____

If yes, please state:

Name of Medication _____ Dosage: _____ mg _____ times per day

Name of Medication _____ Dosage: _____ mg _____ times per day

Name of Medication _____ Dosage: _____ mg _____ times per day

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

K. What medications, if any, were you taking to control the medical condition for which Serzone® was prescribed, prior to beginning Serzone®? (If you do not know or do not recall, please indicate.)

Medication	Yes	No	I Don't Know	Date First Taken/Dosage	Date Last Taken/Dosage

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

VI. MEDICAL BACKGROUND

A. Height: _____

B. Current Weight: _____

C. Lowest Adult Weight: _____

From _____ to _____

D. Highest Adult Weight: _____

From _____ to _____

E. Average Adult Weight: _____

F. To the best of your knowledge, have you ever taken any of the following medications or their generic equivalent? (If you do not know or do not recall, please indicate.)

Medication	Yes	No	I Don't Know	Date First Taken/Dosage	Date Last Taken/Dosage
Aceta- minophen (e.g. Tylenol®)					
Paracetamol					
Nyquil®					
Diclofenac (e.g. Voltaren®)					

Sulindac (e.g. Clinoril®)					
Aspirin					
Ibuprofen (e.g. Advil®, Motrin®)					
Penicillin					
Carbenicillin					
Oxacillin					
Amoxicillin					
Erythromycin					
Tetracyclines					
Sulfonamides					
Antifungal agents					
Ketoconazole					
Fluconazole					
Anti-TB drugs					
Rifampin					
Isoniazid (INH)					
Zidovudine					
Didanosine					
Fialuridine					
Interferon alpha					
Oral Contraceptives Type:					
Estrogens Type:					
Anabolic steroids Type:					
Androgenic steroids Type:					
Flutar					
Hormones Type:					
Niacin					
HMG COA reductase					
Halothane (anesthetic)					

Chloropro- mazine (e.g. Thorazine®)					
Carba- mazepine (e.g. Tegretol®)					
Phenytoin (e.g. Dilantin®)					
Valproic acid (e.g. DepaKenc®)					
Antipsychotics Type:					
Amiodarone					
Alpha- methyldopa (e.g. Aldomet®)					
Ace inhibitors Type:					
Calcium channel blockers Type:					
Methotrexate					
Fluorouracil (5-FU)					
Azathioprine					
Cyclosporine					
Chemothera- peutic agents Type:					
Immunosup- pressive agents Type:					
Vicodin®					
Duract®					
Tagamet®					
Entex®					
Vibramycin®					
Darvocet®					
Rezulin®					
Vancenase®					
Cipro®					
Relafen®					
Daypro®					

Ultram®					
Biazin®					
Paxil®					
Allergy medications Type:					
Herbal preparations Type:					

G. List any other prescription medications taken by you from fifteen (15) years before the onset of the condition for which Serzone® was prescribed until today:

H. For any of the medications you indicated you have taken in subpart F and G of this section, did you experience any adverse reaction associated with that medication?

Yes _____ No _____

If so, for each adverse reaction, please:

Describe the reaction:

Provide approximate date and duration of the reaction:

Did you discontinue use of this medication?:

Did you seek medical attention for the adverse reaction? _____

If yes, please provide the name, address and telephone number of the person or entity that provided the medical attention, the dates of treatment, and a description of the treatment rendered:

I. To the best of your knowledge, have you used, ingested or been exposed to any of the following during the course of your employment:

	Yes	No	I Don't Know	Dates of Use, Ingestion or Exposure
Insecticides Name/type of insecticide (if known):				
Floor wax Type of floor wax (if known):				
Cleaning supplies Name/type of cleaning supplies (if known):				
Dry cleaning chemicals Name/type of dry cleaning chemicals (if known):				
Asbestos				
Hazardous waste material Type of hazardous waste material:				
Vinyl chloride				

Carbon tetrachloride (fire extinguishers, solvents, fumigants)				
Benzene				
Chlorinated hydrocarbons				
Arsenic (dyes, paint, petroleum, ceramic, semi-conductors)				
Aflatoxin (nuts, corn, wheat, barley, soybeans)				
Amanita mushroom poisoning				

J. To the best of your knowledge, state which of the following tests/studies you have undergone within the past fifteen (15) years.

Tests/Studies	Yes	No	I don't know	If yes, healthcare provider performing procedure	If yes, date(s) of procedure	If yes, results of procedure
Radiographic studies (e.g. x-ray)						
Sonographic studies (e.g. liver sonogram)						
Biopsy						
Liver transplant						
Liver function testing and/or monitoring						

Blood studies (e.g., liver enzymes)						
Hepatitis testing						
Other Type:						

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

K. Smoking history [Check 1, 2 or 3 and answer the appropriate subsection.]

1. never smoked cigarettes _____
2. past smoker of cigarettes _____
date on which smoking ceased _____
amount smoked: _____ packs per day for _____ years
3. current smoker of cigarettes _____
amount smoked: _____ packs per day for _____ years

L. Alcohol consumption history

1. Do you now or have you in the past consumed alcohol (beer, wine, whiskey, etc.)?
Yes _____ No _____
2. If yes, check the box which represents your greatest alcohol consumption during any period of time.

Number of Drinks	Yes	Your Age at the Time?	Over what period of time?
1-5 drinks per week			
6-10 drinks per week			
More than 15 drinks per week			

M. To the best of your knowledge, have you ever been told by any doctor or healthcare provider that you have, may have, or had any of the following:

Condition	Yes	No	I don't know	If yes, name, address and telephone number of individual making the diagnosis	If yes, date of diagnosis
Hyperglycemia (elevated blood sugar)					
Hyperinsulinemia					
Nephropathy (kidney disease)					
Retinopathy					
Glaucoma					
Vascular disease					
Autoimmune disease					
Systemic lupus erythematosus (SLE)					
Scleroderma (systemic sclerosis)					
Rheumatoid arthritis					
Cancer					
Leukemia					
Lymphoma/Hodgkin's disease					
Liver disease					
Dark urine					
Jaundice					
Liver enzyme abnormalities					

Hypo- thyroidism					
Hyper- thyroidism					
Wilson's disease					
Hema- chromatosis					
Bacterial infections					
Spirochetal infections					
Parasitic disease					
Fungal liver disease					
Liver abscesses, cysts or tumors					
Tuberculosis					
Sarcoidosis					
Crohn's disease					
HIV and associated viral infections					
Amyloidosis					
Cardiac/heart disease					
Nephrogenic liver dysfunction					
Collagen vascular diseases					
Hematologic disease					
Nyman-Pick disorder					
Wolman's disease					
Tangier disease					
Metabolic disorders					

Antitrypsin deficiency					
Tyrosinemia					
Galactosemia					
Reyes syndrome					
Ischemic hepatic injury associated with heart disease					
Hepatitis A					
Hepatitis B					
Hepatitis C					
Hepatitis D					
Hepatitis E					
Alcoholic, toxic or drug-related hepatitis					
Nonalcoholic steatohepatitis (NASH) or fatty liver					
Hepatic vein occlusion (Budd Chiari Syndrome)					
Autoimmune hepatitis					
Acute fatty liver of pregnancy (if female)					
Substance abuse					
Alcohol abuse					
Cirrhosis of the liver					
Gallbladder disease					
Obesity					
Shortness of breath					

Hypertension					
Angina (chest pain)					
Athero- sclerosis					
Aterio- sclerosis (hardening of the arteries)					
Myocardial infarction (heart attack)					
Congestive heart failure (CHF)					
Pulmonary/lu ng disorders					
Emphysema					
Asthma					
Measles, mumps ruebella					

N. If you are completing this Fact Sheet as the representative of a deceased person, what was the date of death? _____

Was an autopsy performed?

Yes _____ No _____

If yes, at which facility?

Name of Facility

Address

VII.

INJURIES CLAIMED AS A RESULT OF SERZONE® USE

- A. 1. Have you had discussions with any healthcare provider about whether your condition is related to Serzone®?

Yes _____ No _____ I don't know _____

2. If yes, check one of the following:

- a. I was told my condition is related to Serzone®. _____
- b. I was told my condition is not related to Serzone®. _____
- c. I was told my condition may be related to Serzone®. _____
- d. I was told by the healthcare provider that he does not know whether my condition is related to Serzone®. _____
- e. I don't recall what I was told. _____

3. Identify the healthcare provider(s) (name, address and telephone number) with whom you have had these discussions:

Name

Address and telephone number

4. If discussed with more than one healthcare provider, please copy and complete Parts 2 and 3 for each healthcare provider.

- B. Were you told by any healthcare provider that you have a dormant medical condition or have an increased risk of future disease or injury caused by your Serzone® use?

Yes _____ No _____ I don't know _____

If yes, please identify the following: the healthcare provider (name, address and telephone number) with whom you have had these discussions; the nature of the dormant medical condition or risk of future disease or injury; and the recommended course of action to address that risk.

Name

Address and Telephone Number

Nature of dormant medical condition or risk of future disease or illness

Recommended course of action

- C. List any other causes or contributing factors identified by your healthcare provider regarding the injury, dormant medical condition or increased risk of future disease or injury identified above:

- D. Were you given any written instructions or warnings regarding Serzone® at the time of your initial prescription or at any time during which you were using the drug?

Yes _____ No _____ I don't know _____

If yes, please provide the following: the approximate date the written instructions or warnings were given; the name address and telephone number of each person or entity from whom you received the warnings or instructions; the substance of the warnings or instructions; the current location and/or custodian of the written warnings or instructions; and attach a copy of the written warnings or instructions to your completed Fact Sheet..

Approximate date given: _____

Name, address and telephone number of person or entity providing the instructions or warnings

The substance of the instructions or warnings

The current location and/or custodian of the written instructions or warnings

- E. Were you given any oral instructions or warnings regarding Serzone® at the time of your initial prescription or at any time during which you were using the drug?

Yes _____ No _____ I don't know _____

If yes, please provide the following: when the oral instructions or warnings were given; the name address and telephone number of the person or entity from whom you received the warnings or instructions; and the substance of those warnings or instructions.

Approximate date: _____

Name, Address and Telephone Number of person or entity

The substance of those warnings or instructions.

- F. If you claim that any promises, assurances or representations made to you regarding Serzone® were broken, please provide the following: the substance of any such promises, assurances or representations; when, how and to whom they were made; the name, address and telephone number of any person with knowledge of the promise, assurance or representation; and attach any documents reflecting the promise, assurance or representation or its breach.

-
- G. If you claim that any of your doctor(s) or healthcare provider(s) relied on any promises, assurances or representations regarding Serzone®, please provide the following: the name, address and telephone number of the person(s) making such promise, assurance or representation; the substance of any such promise, assurance or representation; the date it was made; and the name address and telephone number of the person to whom it was made:
-
-
-
-

- H. Complete the following information with respect to your employment for the past fifteen (15) years

Name of employer	Employer address and telephone number	Type of business/ position held	Dates of employment	Salary or, if self-employed, income

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

1. State the total amount of time which you have lost from work as a result of any condition which you claim or believe was caused by your use of Serzone® and your personal understanding of the amount of income which you lost.

2. State your earned income for each of the last five years.

Year	Income
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

- I. Have you paid or incurred any medical expenses, including amounts billed or paid by insurers and other third party payors, which are related to any condition which you claim or believe was caused by your use of Serzone® and for which you seek recovery in the action which you have filed?

Yes _____ No _____ I don't know _____

If yes, state the total amount of such expenses at this time. \$ _____

[PLEASE ITEMIZE THIS TOTAL USING AN ATTACHED SHEET]

- J. If any person (not identified elsewhere in this questionnaire) has knowledge or information concerning your use of Serzone® and/or the injuries you claim as a result of your use, please provide the information requested below:

Person's name, address and telephone number	Relation to you, if any	Nature of knowledge or information

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

K. Clinical Studies

Have you ever participated in a Serzone® clinical study trial?

Yes _____ No _____

If yes, what was the name of the study?

What was the date you enrolled in the study? _____

To which health care facility did you report?

Facility

Address

City, State Zip Code

To whom did you report?

Name of health care professional.

Address

City, State Zip Code

L. Other Clinical Studies

Have you ever participated in other clinical study trials?

Yes _____ No _____

If yes, what was the name of the study?

What was the date you enrolled in the study? _____

To which health care facility did you report?

Facility

Address

City, State Zip Code

To whom did you report?

Name of health care provider.

Address

City, State Zip Code

VIII. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

List the name and address of each of the following:

A. Your current family physician:

Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Since when: _____

B. Each **healthcare provider** who has seen or treated you in the past fifteen (15) years.

1. _____
Name

Specialty

Street Address

City, State, Zip Code

Telephone Number

2. _____
Name

Specialty

Street Address

City, State, Zip Code

Telephone Number

3. _____
Name

Specialty

Street Address

City, State, Zip Code

Telephone Number

4. _____
Name

Specialty

Street Address

City, State, Zip Code

Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

C. Each **hospital** where you have received **inpatient** treatment during the past fifteen (15) years:

1.

Name

Specialty

Street Address

City, State, Zip Code

Telephone Number

2.

Name

Specialty

Street Address

City, State, Zip Code

Telephone Number

3.

Name

Specialty

Street Address

City, State, Zip Code

Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

D. Each **hospital or healthcare facility** where you have received **outpatient** treatment (including treatment in an emergency room) during the past fifteen (15) years:

1. _____
Name

Specialty

Street Address

City, State, Zip Code

Telephone Number

2. _____
Name

Specialty

Street Address

City, State, Zip Code

Telephone Number

3. _____
Name

Specialty

Street Address

City, State, Zip Code

Telephone Number

4. _____
Name

Specialty

Street Address

City, State, Zip Code

Telephone Number

5.

Name

Specialty

Street Address

City, State, Zip Code

Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

E. Each **pharmacy** or **drugstore** where you have had prescriptions filled during the past fifteen (15) years:

1.

Name

Street Address

City, State, Zip Code

Telephone Number

2.

Name

Street Address

City, State, Zip Code

Telephone Number

3.

Name

Street Address

City, State, Zip Code

Telephone Number

4.

Name

Street Address

City, State, Zip Code

Telephone Number

5.

Name

Street Address

City, State, Zip Code

Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

- F. If you have submitted a claim **for social security disability benefits** within the past fifteen (15) years, state the name and address of the office which is most likely to have records concerning each claim filed.

1.

Name

Street Address

City, State, Zip Code

Telephone Number

2.

Name

Street Address

City, State, Zip Code

Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

- G. If you have submitted a claim for **workers compensation** within the past fifteen (15) years, state the name and address of the office which is most likely to have records concerning each claim.

Name

Street Address

City, State, Zip Code

If you were represented by counsel please provide:

Attorney's Name

Street Address

City, State, Zip Code

Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

- H. Do you currently have **private health insurance**?

Yes _____ No _____

If so, provide the following:

Name of Health Insurance Company: _____

Street Address

City, State, Zip Code

I. Identify all other health, life and/or disability insurance you have or have had during the past fifteen (15) years (either on an individual basis or as a member of an insured family, including group coverage and coverage under policies of insurance issued to or on behalf of parents and/or spouses).

1. Name of Insurance Company: _____

Street Address

City, State, Zip Code

Dates of Coverage

2. Name of Insurance Company: _____

Street Address

City, State, Zip Code

Dates of Coverage

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

J. Have you ever been denied insurance coverage?

Yes _____ No _____

If so, identify the following:

Name and address of company which denied coverage: _____

Reason(s) coverage was denied: _____

Date(s) on which coverage denied: _____

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

IX. DOCUMENTS

Please provide a true and correct copy of all documents and things (e.g., written documents, photographs, drawings, sketches, videotapes, audiotapes and anything that may be on any computer or that you may have seen on the Internet) which fall into the categories listed below. This includes documents and things in your personal possession, as well as items being held for you by another person, including your lawyer, friends or any relatives.

- 1 All medical records, reports, billing statements and/or invoices, including psychiatric or psychological records, from any physician, hospital, clinic, healthcare provider or pharmacy that treated you, or filled your prescriptions, during the last fifteen (15) years.
- 2 All prescriptions, receipts, physician or office records, drug containers, packaging and other records which refer or relate to any medication referred to in Sections V or VI of this Fact Sheet.
- 3 All documents (e.g., applications, forms, statements, hearing transcripts, medical records, medical reports, orders or directives) that refer or relate to any claim for disability benefits made by you or filed on your behalf (e.g., claims for: medical insurance benefits; insurance benefits; worker's compensation benefits; or any sickness, accident or disability benefits) during the last fifteen (15) years.
- 4 All documents (e.g., correspondence, pleadings, interrogatories and their responses, statements, deposition transcripts, medical records or reports, expert records or reports) that refer or relate to any law-suit filed by you or on your behalf wherein you sought compensation for any physical, psychological or emotional injuries.
- 5 Except to the extent that such documents have been prepared by consulting experts, all photographs, x-rays, motion pictures, videotapes, drawings, or other visual reproduction of any type depicting the injuries and/or damages described in your Complaint or sought by you in this lawsuit.
- 6 If you claim or expect to claim that you lost earnings or earning capacity as a result of any condition which you believe was caused by your use of Serzone®, all documents that refer or relate to your employment or self-employment during the past fifteen (15) years, including but not limited to the following:
 - A. All federal and state tax returns, including all schedules and attachments thereto, and all W-2 and 1099 forms;
 - B. All documents that refer or relate to any termination of employment;
 - C. All documents that refer or relate to any job reviews or evaluations and/or performance appraisals;

- D. All health questionnaires and documents that refer or relate to the results of any medical examination or treatment associated with any such employment or self-employment; and
- E. All written applications for employment that you have made.

7 If you claim to have suffered any injury or damages as a result of taking Serzone®, all documents that refer or relate to that injury and/or damages you claim to have sustained as a result of your ingestion of Serzone® (e.g., medical records, reports, charts, diaries, notes, photographs, videos, recordings, statements, billing statements and/or invoices).

8 All packaging (including the bottle, box and label), instructions, product warnings, package inserts, advertising materials, pamphlets, magazine or newspaper articles, internet information, promotional materials, any documents or materials from defendants, or pharmacy handouts regarding Serzone®.

9 If you participated in any clinical studies, tests or trials regarding Serzone®, all documents relating to such clinical studies, tests or trials.

10 All diaries, chronicles or journals that you have kept during the period from the date you began taking Serzone® to the present that record events related to the medical condition that led to your use Serzone®, your use of medications to treat or control the medical condition that led to your use Serzone®, and/or any injury or damages claimed in this action.

11 Decedent's death certificate, if applicable, and letters testamentary or letters of administration relating to your status as plaintiff, if applicable.

X. AUTHORIZATIONS

Complete and sign the attached Authorizations for the Release of Medical Records, Employment Records and Educational Records.

If you have filed a Workers' Compensation claim, a Social Security disability claim or any other disability claim, please complete and sign the attached Authorization for Release of documents associated with such disability claims.

DECLARATION

I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief; that all of the information provided in response to the List of Medical Providers and Other Sources of Information is true and correct to the best of my knowledge, information and belief; that I have supplied true and accurate copies of all the documents requested in part IX of this declaration, to the extent that such documents are in my possession or control or in the possession of my lawyers; and that I have supplied the authorizations attached to this declaration.

Signature _____

Date _____

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

IN RE SERZONE :
PRODUCTS LIABILITY LITIGATION : MDL Docket No. 1477

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS – EXHIBIT B

To: _____
Name

Address

City, State and Zip Code

This will authorize you to furnish copies of all medical records, reports, radiographic or other films and images, prescription records, written statements, disability records, medical bills, and other documents in your possession including records of treatment for psychological, psychiatric or emotional problems, concerning:

Name of Patient

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

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

Name of Representative

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 acknowledgment at the bottom of this authorization.

Date: _____
Patient or Guardian Signature

Date: _____
Witness Signature

STATE OF _____;
COUNTY OF _____;

Taken, subscribed and sworn to before me this _____ day of _____ 2002.

My commission expires: _____

NOTARY PUBLIC

ACKNOWLEDGMENT

The undersigned, as the record requestor named in the above authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the person (or the person, if not represented) named in the foregoing authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed and has been afforded an opportunity to object to the request and to order copies of the records requested from the undersigned requestor at a reasonable cost pursuant to the terms of Discovery Order # 5, entered by the Honorable Mary E. Stanley, U.S. Magistrate Judge, in the matter of: *In re. Serzone Products Liability Litigation*, MDL 1477.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

IN RE SERZONE :
PRODUCTS LIABILITY LITIGATION : MDL Docket No. 1477

AUTHORIZATION FOR RELEASE OF EMPLOYMENT
AND UNEMPLOYMENT RECORDS -- EXHIBIT C

To: _____
Name

Address

City, State and Zip Code

This will authorize you to furnish copies of all written applications for employment, all employment records, wage records, W-2 and 1099 forms, all documents that refer or relate to any job reviews or evaluations and/or performance appraisals, all documents that refer or relate to any termination of employment, disability records, each health questionnaire and each document that refers or relates to the results of any medical examinations or treatments for any such employment, medical bills, written statements and other documents in your possession concerning:

Name of Employee

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

_____.

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

Name of Representative

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 acknowledgment at the bottom of this authorization.

Date: _____

Employee or Guardian Signature

Date: _____

Witness Signature

STATE OF _____;
COUNTY OF _____;

Taken, subscribed and sworn to before me this _____ day of _____ 2002.

My commission expires: _____

NOTARY PUBLIC

ACKNOWLEDGMENT

The undersigned, as the record requestor named in the above authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the person (or the person, if not represented) named in the foregoing authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed and has been afforded an opportunity to object to the request and to order copies of the records requested from the undersigned requestor at a reasonable cost pursuant to the terms of Discovery Order #5, entered by the Honorable Mary E. Stanley, U.S. Magistrate Judge, in the matter of: *In re. Serzone Products Liability Litigation*, MDL 1477.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

IN RE SERZONE :
PRODUCTS LIABILITY LITIGATION : MDL Docket No. 1477

AUTHORIZATION FOR RELEASE OF EDUCATION RECORDS – EXHIBIT D

To: _____
Name

Address

City, State and Zip Code

This will authorize you to furnish copies of all educational records, including, but not limited to, copies of grades, standardized test scores, psychological testing, guidance counselor records, records of visits with mental health professionals, medical records, records of notes regarding academic achievements and extra-curricular activities, and copies of any notes including any and all information reflecting disciplinary actions or behavioral outbursts, concerning:

Name of Individual

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

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

Name of Representative

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 acknowledgment at the bottom of this authorization.

Date: _____
Individual or Guardian Signature

Date: _____
Witness Signature

STATE OF _____;
COUNTY OF _____;

Taken, subscribed and sworn to before me this _____ day of _____ 2002.
My commission expires: _____

NOTARY PUBLIC

ACKNOWLEDGMENT

The undersigned, as the record requestor named in the above authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the person (or the person, if not represented) named in the foregoing authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed and has been afforded an opportunity to object to the request and to order copies of the records requested from the undersigned requestor at a reasonable cost pursuant to the terms of Discovery Order # 5, entered by the Honorable Mary E. Stanley, U.S. Magistrate Judge, in the matter of: *In re. Serzone Products Liability Litigation*, MDL 1477.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

IN RE SERZONE :
PRODUCTS LIABILITY LITIGATION : MDL Docket No. 1477

AUTHORIZATION FOR RELEASE OF WORKERS' COMPENSATION,
SOCIAL SECURITY, AND OTHER DISABILITY RECORDS - EXHIBIT E

To: _____
Name

Address

City, State and Zip Code

This will authorize you to furnish copies of all documents in your possession, including but not limited to, applications, evaluations, examinations, determinations, correspondence, or any other documents, related in any way to state workers' compensation, Social Security Administration and/or state employment security, or any other disability filings or applications in your possession concerning:

Name of Employee

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

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

Name of Representative

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 acknowledgment at the bottom of this authorization.

Date: _____

Employee or Guardian Signature

Date: _____

Witness Signature

STATE OF _____;
COUNTY OF _____;

Taken, subscribed and sworn to before me this _____ day of _____ 2002.

My commission expires: _____

NOTARY PUBLIC

ACKNOWLEDGMENT

The undersigned, as the record requestor named in the above authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the person (or the person, if not represented) named in the foregoing authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed and has been afforded an opportunity to object to the request and to order copies of the records requested from the undersigned requestor at a reasonable cost pursuant to the terms of Discovery Order #5, entered by the Honorable Mary E. Stanley, U.S. Magistrate Judge, in the matter of: *In re. Serzone Products Liability Litigation*, MDL 1477.