UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

In re: Cook Medical, Inc. Pelvic Repair System Products Liability Litigation	))	MDL No. 2440

THIS DOCUMENT RELATES TO ALL CASES

PRETRIAL ORDER # 8
(Plaintiff Profile Forms, Plaintiff Fact Sheet, and Defendant Fact Sheet)

This Order shall govern (1) all cases transferred to this court by the Judicial Panel on Multidistrict Litigation, including those cases identified in the original Transfer Order and those subsequently transferred as tag-along actions; and (2) all cases directly filed in or removed to this MDL. It is **ORDERED** as follows:

1. Plaintiff Profile Form ("PPF")

a. The parties have agreed upon the use of an abbreviated Plaintiff Profile Form ("PPF") (Exhibit 1), including nine (9) releases (Exhibit A to Exhibit 1), attached to this Order.[1] The PPF shall be completed in each case currently pending in, and in all cases that become part of this MDL by virtue of being filed in, removed to, or transferred to this court.

b. Each plaintiff in currently filed cases that are a part of this MDL as of the date of the entry of this Order shall submit a completed PPF to defendants within 60 days of the date of this Order. In cases filed or transferred after the date of this Order, each plaintiff shall submit a completed PPF to defendants within 60 days of filing the Short Form Complaint. Every plaintiff is required to provide defendants with a PPF that is substantially complete in all respects, answering every question in the PPF, even if a plaintiff can answer the question in good faith

[1] The court refers the parties to the court's website at www.wvsd.uscourts.gov where the PPF (in word and PDF fillable format) and the releases (in PDF fillable format) are located under "forms" for this MDL.

only by indicating "not applicable." The PPF shall be signed by plaintiff under penalty of perjury. If a plaintiff is suing in a representative or derivative capacity, the PPF shall be completed by the person with the legal authority to represent the estate or person under legal disability. Plaintiff spouses with a claim for loss of consortium shall also sign the PPF, attesting that the responses made to the loss of consortium claim questions in the PPF are true and correct to the best of his or her knowledge, information and belief, formed after due diligence and reasonable inquiry.

c. Plaintiffs must forward the Plaintiff Profile Form via U.S. mail or e-mail to the following:

Douglas B. King
Jennifer L. Schuster
Gayle M. Williams
Wooden & McLaughlin LLP
211 N. Pennsylvania St., Suite 1800
Indianapolis, IN 46204

OR

CookMDL@woodmclaw.com

d. A completed PPF shall be considered interrogatory answers under Fed. R. Civ. P. 33 and responses to requests for production under Fed. R. Civ. P. 34, and will be governed by the standards applicable to written discovery under Federal Rules 26 through 37. The interrogatories and requests for production in the PPF shall be answered without objection as to the question posed in the agreed upon PPF. This section does not prohibit a plaintiff from withholding or redacting information from medical or other records provided with the PPF based upon a recognized privilege. If information is withheld or redacted on the basis of privilege, plaintiff

shall provide defendants with a privilege log that complies with Rule 26(b)(5) simultaneously with the submission of the PPF.

e. Contemporaneous with the submission of a PPF, each plaintiff shall provide the defendants with hard copies or electronic files of all medical records in their possession or control, including, in particular, records that support product identification.

f. Contemporaneous with the submission of a PPF, each plaintiff shall also produce signed authorizations, which are attached to the PPF as Exhibits and located in PDF fillable format on the court's website, for the release to co-lead counsel for Defendants of medical, Union, psychotherapy, insurance, Medicaid, employment, Workers' Compensation, Social Security and Medicare records from each healthcare provider, hospital, clinic, outpatient treatment center, or any other entity, institution, agency or other custodian of records identified in the PPF or which applies to the plaintiff. The signed authorizations shall be undated and the recipient line shall be left blank. These blank, signed authorizations constitute permission for co-lead counsel for the Defendants to obtain the records specified in the authorizations from the records custodians. In the event an institution, agency or medical provider to which a signed authorization is presented refuses to provide responsive records, the individual plaintiff's attorney shall attempt to resolve the issue with the institution, agency, or provider, such that the necessary records are promptly provided. Any records that pertain to psychiatric related care whether by a psychiatrist or psychologist shall first be available to counsel for the plaintiff who shall have 10 days to assert a recognized privilege and notify counsel for the requesting defendant, with an appropriate privilege log. Absent notification within 10 days of the assertion of such a privilege, counsel for the plaintiff shall then provide the records to the requesting defendant.

g. Each plaintiff shall immediately preserve and maintain, without deletions or alterations, any content of any personal webpage(s) or social media accounts currently held by them, including but not limited to, photographs, text, links, messages and other postings or profile information that is relevant to the subject matter of this litigation. “Social media” includes, but it not limited to, Facebook, MySpace, Linked In, Friendster, and/or blogs. The plaintiffs shall preserve this data by downloading it to a suitable storage device, by printing out copies on paper, or by other means consistent with law and court rules applicable to document and data preservation.

h. If a plaintiff does not submit a PPF within the time specified in this Order, defendants may move immediately to dismiss that plaintiff’s case without first resorting to these deficiency cure procedures.

i. If defendants receive a PPF in the allotted time but the PPF is not substantially complete, defendants’ counsel shall send a deficiency letter within 10 days of receipt of a PPF, as applicable by e-mail and U.S. mail to Plaintiffs’ Co-Lead Counsel and the plaintiffs’ individual representative counsel, identifying the purported deficiencies. Plaintiff shall have twenty (20) days from receipt of that letter to serve a PPF that is substantially complete in all respects. This letter shall include sufficient detail for the parties to meet and confer regarding the alleged deficiencies.

j. Any plaintiff who fails to comply with the PPF obligations under this Order may, for good cause shown, be subject to sanctions, to be determined by the court, upon motion of the defendants.

2. Plaintiff Fact Sheet (PFS)

a. Within 60 days of the entry of a Pretrial Order identifying the Discovery Pool Cases, those plaintiffs identified in that Order shall submit a full Plaintiff Fact Sheet ("PFS"), in the form attached hereto as Exhibit 2.

b. Contemporaneous with the submission of their PFS, plaintiffs shall provide the following categories of information posted by the plaintiff on any social media websites identified in the PFS disclosures:

1) Photographs and/or videos, if any, posted by the plaintiff which show the plaintiff taking part in physical activity from one year preceding the date of her pelvic repair surgery(ies) through the date of the signing of the PFS and any comments, posts, or messages made by the plaintiff related to same. "Physical activity" is defined as strenuous physical or recreational activity, such as horseback riding, ice skating, scuba diving, snorkeling, swimming, biking, and hiking;

2) Photographs or videos, if any, posted by the plaintiff showing plaintiff in the hospital, at the doctor's office, or recovering after the date(s) of her pelvic repair surgery(ies) at issue, and any comments, posts, or messages made by the plaintiff related to same;

3) Comments, posts or messages, if any, made by the plaintiff regarding pelvic repair product(s) or the surgery(ies) at issue;

4) Comments, posts or messages, if any, made by the plaintiff regarding any significant health conditions of the plaintiff, including but not limited to, her gynecologic, pelvic or abdominal condition from one year preceding the date of her surgery(ies) through the date of the signing of the PFS;

5) Where plaintiff has alleged emotional injury other than pain and suffering, comments, posts or messages, if any, made by plaintiff regarding the plaintiff's emotional condition from one year preceding the date of her surgery(ies) through the date of the signing of the PFS; and

6) Comments, posts, links, messages or pages, if any, made by the plaintiff concerning the plaintiff's lawsuit or pelvic repair litigation in general.

Plaintiffs pursuing a consortium claim shall likewise produce the information set forth in 1) through 6) above that is posted by either plaintiff on his/her social media website(s) regarding the plaintiff in whom the device was implanted.

The information required to be produced pursuant to 1) through 6) above includes any otherwise responsive information that may have been marked "private" on the plaintiff's social media website(s). Where materials produced pursuant to this section contain private medical or other information about a non-party, the plaintiff shall redact identifying and/or any other information pertaining to that non-party.

c. Plaintiffs must forward the Plaintiff Fact Sheet via U.S. mail or e-mail to the following:

Douglas B. King
Jennifer L. Schuster
Gayle M. Williams
Wooden & McLaughlin LLP
211 N. Pennsylvania St., Suite 1800
Indianapolis, IN 46204

OR

CookMDL@woodmclaw.com

If defendants receive a PFS in the allotted time but the PFS is not substantially complete, defendants' counsel shall send a deficiency letter within 10 days of receipt of a PFS, as applicable by e-mail and U.S. mail to the Plaintiffs' Co-Lead Counsel and the plaintiffs' individual representative counsel, identifying the purported deficiencies. The plaintiff shall have twenty (20) days from receipt of that letter to serve a PFS that is substantially complete in all respects. This letter shall include sufficient detail for the parties to meet and confer regarding the alleged deficiencies.

d. Any plaintiff who fails to comply with the PFS obligations under this Order may, for good cause shown, be subject to sanctions, to be determined by the court, upon motion of the defendants.

3. Defendant Fact Sheet ("DFS")

a. A Defendant Fact Sheet ("DFS"), in the form attached hereto as Exhibit 3, shall be completed only in those cases selected as a subgroup (not to exceed 20 cases) from which the final bellwether selection will be made. The DFS shall constitute the initial plaintiff – specific discovery of defendants, and no plaintiff shall serve upon any defendant interrogatories or requests for production of documents that are specific to an individual plaintiff, treating physician, or sales representative prior to service of a DFS for that plaintiff.

b. Defendants shall submit a substantially completed DFS for each case in the "subgroup" identified in 3.a above within 45 days after the entry of the Order establishing the "subgroup" plaintiffs. The DFS shall provide general but comprehensive information concerning the particular product identified in the PPF, and information specific to each individual plaintiff selected as a "subgroup" plaintiff, including, for example, documentation relating to the plaintiff, and defendants' contact(s) with the physician(s) identified by the Plaintiff.

c. A Completed DFS shall be considered interrogatory answers under Fed. R. Civ. P. 33 and responses to requests for production under Fed. R. Civ. P. 34, and will be governed by the standards applicable to written discovery under Federal Rules 26 through 37. The interrogatories and requests for production in the DFS shall be answered without objection as to the question as posed in the agreed upon DFS. However, defendants may assert objections relevant to information specific to an individual plaintiff in the DFS, where appropriate in that case.

d. If a defendant fails to timely submit a DFS, or submits within the allotted time a DFS that is not substantially complete, the Plaintiffs' Co-Lead Counsel shall send a deficiency letter within 10 days of receipt of a DFS by e-mail and U.S. mail to a designated Counsel for that defendant, identifying the purported deficiencies. This letter shall include sufficient detail for the parties to meet and confer regarding the alleged deficiencies. Defendant shall have twenty (20) days from receipt of that letter to serve a DFS that is substantially complete in all respects. Should a defendant fail to cure the deficiencies identified and fail to provide responses that are substantially complete in all respects within twenty (20) days of service of the deficiency letter, plaintiff may move for appropriate relief under Federal Rule of Civil Procedure 37. Any such filing shall be served on Lead Counsel for that defendant, with any response to such filing to be submitted within ten (10) days following the date of service. Any such filing should include the efforts the plaintiffs made to meet and confer regarding the alleged deficiencies in the DFS and failure to cure.

e. A defendant that fails to comply with the DFS obligations under this Order may be subject, for good cause shown, to sanctions, to be determined by the court, including those sanctions set forth in Fed. R. Civ. P. 37.

The Court **DIRECTS** the Clerk to file a copy of this order in 2:13-md-2440 and it shall apply to each member case previously transferred to, removed to, or filed in this district, which includes counsel in all member cases up to and including civil action number 2:13-cv-24110. In cases subsequently filed in this district, a copy of the most recent pretrial order will be provided by the Clerk to counsel appearing in each new action at the time of filing of the complaint. In cases subsequently removed or transferred to this court, a copy of the most recent pretrial order will be provided by the Clerk to counsel appearing in each new action upon removal or transfer. It shall be the responsibility of the parties to review and abide by all pretrial orders previously entered by the court. The orders may be accessed through the CM/ECF system or the court's website at www.wvsd.uscourts.gov.

ENTER: October 8, 2013

JOSEPH R. GOODWIN
UNITED STATES DISTRICT JUDGE

EXHIBIT 1

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

CHARLESTON DIVISION

MDL No. 2440
In Re Cook Medical, Inc. Pelvic Repair System Products Liability Litigation

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In completing this **Plaintiff Profile Form**, you are under oath and must provide information that is true and correct to the best of your knowledge. The Plaintiff Profile Form shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order.

I. CASE INFORMATION

Caption: _____ **Date:** _____
Docket No.: _____
Plaintiff's attorney and Contact information:
_____
_____
_____
_____

II. PLAINTIFF INFORMATION

Name: _____
Spouse: _____**Loss of Consortium?** □**Yes** □ **No**
Address: _____
Date of birth: _____
Social Security No.: _____

III. DEVICE INFORMATION[1]

Date of implant: _____
***Reason for Implantation**:* _____
Brand Name: _____ **Mfr.** _____
Lot Number: _____
Implanting Surgeon: _____
Medical Facility: _____

[1] Note: In lieu of device information, operating records may be submitted as long as all requested information is legible on the face of the record.

Date of implant: _____
Reason for Implantation: _____
Brand Name: _____ **Mfr.** _____
Implanting Surgeon: _____
Medical Facility: _____

• Attach medical evidence of product identification.

IV. REMOVAL/REVISION SURGERY INFORMATION

Date of surgery(s): _____
Type of surgery(s): _____
Explanting surgeon: _____
Medical Facility: _____
Reason for Explant: _____

Date of surgery(s): _____
Type of surgery(s): _____
Explanting surgeon: _____
Medical Facility: _____
Reason for Explant: _____

V. OUTCOME ATTRIBUTED TO DEVICE

□ **Pain**	□ **Fistulae**
□ **Erosion**	□ **Recurrence**
□ **Extrusion**	□ **Bleeding**
□ **Infection**	□ **Dyspareunia**
□ **Urinary Problems**	□ **Neuromuscular problems**
□ **Bowel Problems**	□ **Vaginal Scarring**
□ **Organ Perforation**	□ **Other**

VI. PAST HISTORY

Number of Pregnancies: _____ Number of Live Births: _____
Date of Hysterectomy(ies) and Name of Hospital Where Performed: _____
Prior to the First Implant, Had You Ever Had:

_____ Lupus
_____ Diabetes
_____ Auto Immune Disorder
_____ Endometriosis
_____ Pelvic Pain Syndrome or Disorder
_____ Fibroids
_____ Adhesive Disease

Are you claiming damages for lost wages: [ ] Yes [ ] No
If so, for what time period: _____
Have you ever filed for bankruptcy: [ ] Yes [ ] No
If so, when? _____

Do you have a computer: [ ] Yes [ ] No

If so, are you a member of Facebook, LinkedIn or other social media websites:
[ ] Yes [ ] No

Which ones: _____

VII. LIST ALL TREATING PHYSICIANS FROM A PERIOD OF 10 YEARS PRIOR TO THE FIRST PELVIC REPAIR IMPLANT TO THE PRESENT, INCLUDING ALL PRIMARY CARE PHYSICIANS, OB-GYNS, UROLOGISTS, ENDOCRINOLOGISTS, RHEUMATOLOGISTS, PSYCHIATRISTS, PSYCHOLOGISTS, OR ANY OTHER SPECIALISTS

Primary Care Physicians:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

OB-GYNs:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Urologists:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Psychiatrists/Psychologists (Answer only if making a claim for emotional/psychological injury beyond usual pain and suffering):

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Attach additional pages as needed to identify other health care providers you have seen.

AUTHORIZATIONS

Provide ONE (1) SIGNED ORIGINAL copy of each of the records authorization forms attached in Exhibit A. These authorization forms will authorize co-lead for Defendants to obtain those records identified in the authorizations from the providers identified within this Plaintiff Profile Form and, if applicable, the Plaintiff Fact Sheet.

VERIFICATION

I, _____, declare under penalty of perjury subject to all applicable laws, that I have carefully reviewed the final copy of this Plaintiff Profile Form dated _____ and verified that all of the information provided is true and correct to the best of my knowledge, information and belief.

_____
Signature of Plaintiff

VERIFICATION OF LOSS OF CONSORTIUM

I, _____, declare under penalty of perjury subject to all applicable laws, that I have carefully reviewed the final copy of this Plaintiff Profile Form dated _____ and verified that all of the information provided is true and correct to the best of my knowledge, information and belief.

_____
Signature of Consortium Plaintiff

EXHIBIT A

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

To:

I, the undersigned, hereby authorize and request the Custodian above-named entity to disclose to Wooden & McLaughlin LLP, 211 N. Pennsylvania St., Suite 1800, Indianapolis, IN 46204 any and all medical records, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. This authorization specifically does not permit Wooden & McLaughlin LLP to discuss any aspect of medical care or circumstances ex parte and without the presence of my attorney. Records requested may include, but are not limited to:

a) all medical records, physician's records, surgeon's records, pathology/cytology reports, physicals and histories, laboratory reports, operating room records, discharge summaries, progress notes, patient intake forms, consultations, prescriptions, nurses' notes, birth certificate and other vital statistic records, communicable disease testing and treatment records, correspondence, prescription records, medication records, orders for medications, therapists' notes, social worker's records, insurance records, consent for treatment, statements of account, itemized bills, invoices and any other papers relating to any examination, diagnosis, treatment, periods of hospitalization, or stays of confinement, or documents containing information regarding amendment of protected health information (PHI) in the medical records, copies (NOT originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports and requisition records, and any other written materials in its possession relating to any and all medical diagnoses, medical examinations, medical and surgical treatments or procedures. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information. This authorization and release does not allow to request or take possession of pathology/cytology specimens, extracted mesh, pathology/cytology or hematology slides, wet tissue or tissue blocks.

b) complete copies of all prescription profile records, prescription slips, medication records, orders for medication, payment records, insurance claims forms correspondence and any other records. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____**v. Cook Medical Inc., et al.** or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Wooden & McLaughlin LLP except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization expressly authorizes the above-named entity to disclose HIV/AIDS records and information to Wooden & McLaughlin LLP.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that she/he shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by Wooden & McLaughlin LLP.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Wooden & McLaughlin LLP.

Name of Patient (Print)	Signature of Patient or Individual
Former/Alias/Maiden Name of Patient	Date
Patient's Date of Birth	Name of Patient Representative
Patient's Social Security Number	Description of Authority
Patient's Address	

AUTHORIZATION AND CONSENT
TO RELEASE PSYCHOTHERAPY NOTES

Name of Individual:
Social Security Number:
Date of Birth:
Provider Name:

TO: All physicians, hospitals, clinics and institutions, pharmacists and other healthcare providers

The Veteran's Administration and all Veteran's Administration hospitals, clinics, physicians and employees

The Social Security Administration

Open Records, Administrative Specialist, Department of Workers' Claims

All employers or other persons, firms, corporations, schools and other educational institutions

The undersigned individual herby authorizes each entity included in any of the above categories to furnish and disclose to Wooden & McLaughlin LLP, 211 N. Pennsylvania St., Suite 1800, Indianapolis, IN 46204 and its authorized representatives, true and correct copies of all "psychotherapy notes", as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's record. This authorization does not authorize ex parte communication concerning same.

- This authorization provides for the disclosure of the above-named patient's protected health information for purposes of the following litigation matter: _____ v. Cook Medical, Inc., et al.

- The undersigned individual is hereby notified and acknowledges that any health care provider or health plan disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

- The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice to Wooden & McLaughlin LLP and/or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.

- The undersigned is hereby notified and acknowledges that he or she is aware of the potential that protected health information disclosed and furnished to the recipient pursuant to this authorization is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and ultimately furnished to Wooden & McLaughlin LLP in accordance with orders of the court pursuant to this authorization will be shared with any and all

co-defendants in the matter of _____ v. Cook Medical, Inc., et al.

- and is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ v. Cook Medical, Inc., et al. or (ii) five (5) years after the date of signature of the undersigned.

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to Wooden & McLaughlin LLP and its authorized representatives, by any entities included in the categories listed above.

Date: _____ _____

Signature of Individual or Individual's Representative

Individual's Name and Address:

_____ _____

Printed Name of Individual's Representative (If applicable)

_____ _____

Relationship of Representative to Individual (If applicable)

_____ _____

Description of Representative's authority to act for Individual (If applicable)

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act, and the regulations promulgated thereunder, 45 CFR Parts 160 and 164 (collectively, "HIPAA").

AUTHORIZATION TO DISCLOSE INSURANCE INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to Wooden & McLaughlin LLP, 211 N. Pennsylvania St., Suite 1800, Indianapolis, IN 46204, any and all records containing insurance information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. Records requested may include, but are not limited to:

> applications for insurance coverage and renewals; all insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverage; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage, or claims; all physicians', hospital, dental reports, prescriptions, correspondence, test results, radiology reports and any other medical records that were submitted for claims review purposes; any claim record filed; records of any claim paid; records of all litigation; and any other records of any kind concerning or pertaining to the insured. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information. By signing this authorization, I expressly do not authorize any ex parte interview or oral communication about me or any information contained in the materials produced without the presence of my attorney.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ **v. Cook Medical, Inc., et al.** or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Wooden & McLaughlin LLP, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that she/he shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by Wooden & McLaughlin LLP.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Wooden & McLaughlin LLP.

Name of Individual	Signature of Individual or Individual Representative
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

AUTHORIZATION TO DISCLOSE MEDICAID INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to the agents or designees of Wooden & McLaughlin LLP, 211 N. Pennsylvania St., Suite 1800, Indianapolis, IN 46204, any and all records containing Medicaid information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. This authorization should also be construed to permit agents or designees of Wooden & McLaughlin LLP to copy, inspect and review any and all such records. Records requested may include, but are not limited to:

> all Medicaid records, including explanations of Medicaid benefit records and claims records; any statements, communications, pro reviews, denials, appeals, correspondence, reports, questionnaires or records submitted in connection with claims; all reports from physicians, hospitals, dental providers, prescriptions; correspondence, test results and any other medical records; records of claims paid to or on the behalf of _____; records of litigation and any other records of any kind. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____v. Cook Medical, Inc., et al. or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation. By signing this authorization, I expressly do not authorize any ex parte interview or oral communication about me or my medical history by Wooden & McLaughlin LLP without the presence of my attorney.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Wooden & McLaughlin LLP, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that they shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by Wooden & McLaughlin LLP.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Wooden & McLaughlin LLP.

Name of Individual	Signature of Individual or Individual
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

AUTHORIZATION TO DISCLOSE EMPLOYMENT INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to Wooden & McLaughlin LLP, 211 N. Pennsylvania St., Suite 1800, Indianapolis, IN 46204, any and all records containing employment information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. Records requested may include, but are not limited to:

> all applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files; all hospital, physician, clinic, infirmary, nurse, dental records; test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; material safety data sheets, chemical inventories, and environmental monitoring records and all other employee exposure records pertaining to all positions held; and any other records concerning employment with the above-named entity. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information. By signing this authorization, I expressly do not authorize any ex parte interview or oral communication about me or my employment history by Wooden & McLaughlin LLP without the presence of my attorney.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ **v. Cook Medical, Inc., et al.** or (ii) five (5) years after the date of signature of the undersigned below. A copy of this authorization may be used in place of and with the same force and effect as the original. The purpose of this authorization is for civil litigation.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Wooden & McLaughlin LLP, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that they shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by Wooden & McLaughlin LLP.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Wooden & McLaughlin LLP.

Name of Employee	Signature of Employee or Employee Representative
Former/Alias/Maiden Name of Employee	Date
Employee's Date of Birth	Name of Employee Representative
Employee's Social Security Number	Description of Authority
Employee's Address	

AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to Wooden & McLaughlin LLP, 211 N. Pennsylvania St., Suite 1800, Indianapolis, IN 46204, any and all records containing Workers' Compensation information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. Records requested may include, but are not limited to:

> all workers' compensation claims, including claim petitions, judgments, findings, notices of hearings, hearing records, transcripts, decisions and orders; all depositions and reports of witnesses and expert witnesses; employer's accident reports; all other accident, injury, or incident reports; all medical records; records of compensation payment made; investigatory reports and records; applications for employment; records of all positions held; job descriptions of any positions held; salary records; performance evaluations and reports; statements and comments of fellow employees; attendance records; all physicians', hospital, medical, health reports; physical examinations; records relating to health or disability insurance claims, including correspondence, reports, claim forms, questionnaires, records of payments made to physicians, hospitals, and health institutions or professionals; statements of account, itemized bills or invoices; and any other records relating to the above-named individual. Copies (NOT originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ **v. Cook Medical, Inc., et al.** or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation. This authorization is for the release of records only and does not allow for ex parte communications regarding the subject matter of this release and without the presence of my attorney.

NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Wooden & McLaughlin LLP, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that they shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by Wooden & McLaughlin LLP.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Wooden & McLaughlin LLP.

Name of Individual	Signature of Individual or Individual Representative
Former/Alias/Maiden Name of Individual	Date
Individual's Date of Birth	Name of Individual Representative
Individual's Social Security Number	Description of Authority
Individual's Address	

AUTHORIZATION TO DISCLOSE UNION RECORDS/INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to Wooden & McLaughlin LLP, 211 N. Pennsylvania St., Suite 1800, Indianapolis, IN 46204, any and all records containing union and/or employment information, including those that may contain protected health information (PHI) regarding _____**,** whether created before or after the date of _____.
Records requested may include, but are not limited to:

> Training records, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of employers, attendance records, worker's compensation files; all hospital, physician, clinic, infirmary, nurse, dental records; test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in union-sponsored health, dental, life and disability insurance plans; material safety data sheets, chemical inventories, and environmental monitoring records and all other employee exposure records pertaining to all positions held; and any other records involving the above-named entity. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information. By signing this authorization, I expressly do not authorize any ex parte interview or oral communication about me or my union history by Wooden & McLaughlin LLP without the presence of my attorney.

A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of _____ **v. Cook Medical, Inc., et al.** or (ii) five (5) years after the date of signature of the undersigned below. A copy of this authorization may be used in place of and with the same force and effect as the original. The purpose of this authorization is for civil litigation.

NOTICE:

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Wooden & McLaughlin LLP, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **The individual signing this authorization understands that they shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by Wooden & McLaughlin LLP.**

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to Wooden & McLaughlin LLP.

_____	_____
Name of Employee	Signature of Employee
_____	_____
Former/Alias/Maiden Name of Employee	Date
_____	_____
Employee's Date of Birth	Name of Employee Representative
_____	_____
Employee's Social Security No.	Description of Authority
_____	
Employee's Address	

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

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

Wooden &McLaughlin LLP

*ADDRESS

211 N. Pennsylvania St. Ste.1800

Indianapolis, IN 46204

*I want this information released because: civil litigation
There may be a charge for releasing information.

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- □ Social Security Number
- □ Current monthly Social Security benefit amount
- □ Current monthly Supplemental Security Income payment amount
- □ My benefit/payment amounts from ____ to ____
- □ My Medicare entitlement from ____ to ____
- □ Medical records from my claims folder(s) from ____ to ____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- □ Complete medical records from my claims folder(s)
- □ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.)

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: ———————————————————— *Date: ____

Relationship *(if not the individual):* *Daytime Phone: ————————

Form SSA-3288 (07-2010) EF (07-2010)

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778). or

Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

Fill in your name, date of birth, and social security number or 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 organization) to whom you want us to release your information.

Indicate the reason you are requesting us to disclose the information.

Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.

You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.

If you are not the person whose information is requested, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. The information you provide will be used to respond to your request for SSA records information or process your request when we release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following: 1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 3. To comply with Federal laws requiring the disclosure of the information from our records; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

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 3 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 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.*

Form SSA-3288 (07-2010) EF (07-2010) Destroy Prior Editions

Medicare

Beneficiary Services:1-800-MEDICARE (1-800-633-4227)
TTY/IDD:1-877-486-2048

This form is used to advise Medicare of the person or persons you have chosen to have access to your personal health information.

Where to Return Your Completed Authorization Forms:
After you complete and sign the authorization form, return it to the address below:

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

For New York Medicare Beneficiaries ONLY
The New York State Public Health Law protects information that reasonably could identify someone as having HIV symptoms or infection, and information regarding a person's contacts. Because of New York's laws protecting the privacy of information related to alcohol and drug abuse, mental health treatment, and HIV, there are special instructions for how you, as a New York resident, should complete this form.

- For question 2A, check the box for *Limited Information,* even if you want to authorize Medicare to release any and all of your personal health information.

- **Then proceed to question 2B.**

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

Instructions for Completing Section 2B of the Authorization Form:
Please select one of the following options.

- **Option 1 To include** all information, in the space provided, write: "all information, including information about alcohol and drug abuse, mental health treatment, and HIV". Proceed with the rest ofthe form.

- **Option 2 To exclude** the information listed above, write "Exclude information about alcohol and drug abuse, mental health treatment and HIV" in the space provided. *You may also check any of the remaining boxes and include any additional limitations in the space provided.* For example, you could write "payment information". Then proceed with the rest of the form.

Ifyou have any questions or need additional assistance, please feel free to call us at 1-800-MEDICARE (1-800-633-4227). TTY users should call1-877-486-2048.

Sincerely,

1-800-MEDICARE
Customer Service Representative

Encl.

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** (First and last name of the person with Medicare)	**Medicare Number** (Exactly as shown on the Medicare Card)	**Date of Birth** (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:**

D Limited Information (go to question 2b)

D Any Information (go to question 3)

2B: **Complete only if you selected "limited information". Check all that apply:**

D Information about your Medicare eligibility

D Information about your Medicare claims

D Information about plan enrollment (e.g. drug or MA Plan)

D Information about premium payments

D 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):

D Disclose my personal health information indefinitely

D 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: Wooden & McLaughlin LLP

      Address: 211 N. Pennsylvania St., Suite 1800
      Indianapolis, IN 46204

   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)

   _____

   _____

   D 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.

EXHIBIT 2

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

In re: Cook Medical, Inc. Pelvic Repair System Products Liability Litigation	))	**MDL No. 2440**

Plaintiff:_____
Name of Plaintiff

Case No:_____

PLAINTIFF FACT SHEET

Each plaintiff who allegedly suffered injury as a result of a Cook Biodesign® or Surgisis® product must complete this Plaintiff Fact Sheet. In completing this Fact Sheet, you are under oath and must answer every question and provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can and then state that your answer is incomplete and explain why as appropriate. If you select an "I Don't Know" answer, please state all that you do know about that subject. If any information you need to complete any part of the Fact Sheet is in the possession of your attorney, please consult with your attorney so that you can fully and accurately respond to the questions set out below. If you are completing the Fact Sheet for someone who cannot complete the Fact Sheet herself, please answer as completely as you can.

The Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. A completed Fact Sheet shall be considered interrogatory answers pursuant to Fed. R. Civ. P. 33 and 34 and will be governed by the standards applicable to written discovery under Fed. R. Civ. P. 26 through 37. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. The questions and requests for production contained in the Fact Sheet are non-

objectionable and shall be answered without objection. This Fact Sheet shall not preclude Defendants from seeking additional documents and information on a reasonable, case-by-case basis pursuant to the Federal Rules of Civil Procedure and as permitted by the applicable Case Management Order.

In filling out this form, please use the following definition: "healthcare provider" means any doctor, physician, surgeon, pharmacist, hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you.

In filling out this form, the terms "You" or "Your" refer to the person who received a Cook Biodesign® or Surgisis® product manufactured by Cook Biotech Incorporated ("Cook Biotech") and who is identified in Question I. 1 (a) below.

To the extent that the form does not provide enough space to complete your responses or answers, please attach additional sheets as necessary.

I. BACKGROUND INFORMATION

1. Please state:

   a) Full name of the person who received the Cook Biodesign® or Surgisis® product(s), including maiden name: _____

   b) Full name of the person completing this form, if different from the person listed in 1 (a) above, and the relationship of the person completing this form to the person listed in 1 (a) above: _____

   c) The name and address of your primary attorney:

2. Your Social Security Number: _____

3. Your date of birth: _____

4. Your current residence address:_____

5. If you have lived at this address for less than 10 years, provide each of your prior residence addresses from 2000 to the present:

Prior Address	Dates You Lived at this Address

6. Have you ever been married? Yes ___ No ___

   If yes, provide the names and addresses of each spouse and the inclusive dates of your marriage to each person:

   _____

   _____

6. Do you have children? Yes ___ No ___

If Yes, please provide the following information with respect to each child:

Full Name of Child	Date of Birth	Home Address (if different from yours)	Whether Biological/Adopted

7. Identify the name and age of any person who currently resides with you and their relationship to you:

8. Identify all secondary and post-secondary schools you attended, starting with high school and please provide the following information with respect to each:

Name of School	Address	Dates of Attendance	Degree Awarded	Major or Primary Field

9. Please provide the following information for your employment history over the past 10 years up until the present:

Employer Name	Address	Job Title/Description of Duties	Dates of Employment	Salary/Rate of Pay

10. Have you ever served in any branch of the military? Yes ___ No ___

If Yes, please provide the following information:

a. Branch and dates of service, rank upon discharge and the type of discharge you received: _____

b. Were you discharged from the military at any time for any reason relating to your medical, physical, or psychiatric condition? Yes ___ No ___

If Yes, state what that condition was: _____

_____

11. Within the last ten years, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty? Yes ___ No ___

If Yes, please set forth where, when and the felony and/or crime:

_____

_____

II. CLAIM INFORMATION

1) Have you ever received a Cook Biodesign® or Surgisis® product? Yes ___ No ___

If Yes, please check the box for each Cook Biodesign® or Surgisis® product you have received:

[ ] Biodesign® or Surgisis® Tension-Free Urethral Sling

[ ] Biodesign® or Surgisis® Urethral Sling

[ ] Stratasis™ Urethral Sling

[ ] Biodesign® or Surgisis® Anterior Pelvic Floor Graft

[ ] Biodesign® or Surgisis® Posterior Pelvic Floor Graft

[ ] Biodesign® or Surgisis® 4-Layer Tissue Graft

[ ] Biodesign® or Surgisis® 1-Layer Tissue Graft

[ ] Biodesign® or Surgisis® 8-Layer Tissue Graft

[ ] Biodesign® or Surgisis® Vaginal Erosion Repair Graft

[ ] Biodesign® or Surgisis® Peyronie's Repair Graft

[ ] Other (please identify): _____

2) For each Cook Biodesign® or Surgisis® product identified above, please provide the following information:

a) The date the Cook Biodesign® or Surgisis® product(s) was implanted in you:

_____

b) The product code and lot number of each Cook Biodesign® or Surgisis® product you received:_____

(NOTE: a label clearly identifying the product code and lot number accompanies every Cook Biodesign® or Surgisis® product and should have been affixed to some page of your hospital records.)

3) Describe your understanding of the medical condition for which you received the Cook Biodesign® or Surgisis® product(s): _____

_____

_____

4) Give the name and address of the doctor who implanted the Cook Biodesign® or Surgisis® product(s): _____

_____

5) Give the name and address of the hospital or other healthcare facility where the Cook Biodesign® or Surgisis® product(s) was implanted: _____

_____

6) In addition to the Cook Biodesign® or Surgisis® product(s) that are the subject of your lawsuit, have you been implanted with any pelvic mesh products? **Yes ___ No ___**

   a. Product Name(s): _____

   b. Date of implantation procedure(s) and name and address of implanting doctor(s): _____

   c. Condition(s) sought to be treated through placement of the device(s): _____

   _____

   d. Whether the product(s) remain implanted inside of you today?
   Yes ___ No ___

7) Prior to implantation with a Cook Biodesign® or Surgisis® product, did you receive any written and/or verbal information or instructions regarding the Cook Biodesign® or Surgisis® product(s), including any risks or complications that might be associated with the use of the product(s)?

Yes ___ No ___ Don't Know____

If Yes:

a) Provide the date you received the written and/or verbal information or instructions:_____

b) Identify by name and address the person(s) who provided the information or instructions:_____

_____

c) What information or instructions did you receive? _____

_____

d) If you have copies of the written information or instructions you received, please attach copies to your response.

8) For each Cook Biodesign® or Surgisis® product(s) that has been implanted in you:

a) Has any doctor recommended removal of the Cook Biodesign® or Surgisis® product(s)? Yes ___ No ___

If Yes, Identify by name and address the doctor who recommended removal and state your understanding of why the doctor recommended removal:_____

_____

_____

9) Has any physician removed any of the Cook Biodesign® or Surgisis® product(s) from you, in whole or in part?

Yes ___ No ___ Don't Know _____

If Yes:

a) On what date, where and by whom (doctor) was the Cook Biodesign® or Surgisis® product, or any portion of it, was removed?_____

_____

c) Explain why you consented to have the Cook Biodesign® or Surgisis® product(s), or any portion of it, removed?_____

_____

_____

d) Does any medical treater, physician, entity, or anybody else on your behalf have possession of any portion of the Cook Biodesign® or Surgisis® product(s) that was previously implanted in you and removed? Yes ___ No ___ Don't Know _____

e) If Yes, please state name and address of the person or entity having possession of same: _____

_____

10) Do you claim that you suffered bodily injuries as a result or the implantation of Cook Biodesign® or Surgisis® product(s)? Yes ___ No ___

If Yes:

a) Describe the bodily injuries, including any emotional or psychological injuries, that you claim resulted from the implantation of Cook Biodesign® or Surgisis® product(s):_____

_____

_____

b) When is the first time you experienced symptoms of any of the bodily injuries you claim in your lawsuit to have resulted from the Cook Biodesign® or Surgisis® product(s)?_____

_____

_____

_____

c) When did you first attribute these bodily injuries to the Cook Biodesign® or Surgisis® product(s)? _____

_____

d) To the best of your knowledge and recollection, please state approximately when you first saw a health care provider for each of those bodily injuries you claim to have experienced relating to the Cook Biodesign® or Surgisis® product(s):

_____

_____

_____

_____

_____

e) Are you currently experiencing symptoms related to your claimed bodily injuries?

Yes ____ No ____

If Yes, please describe your current symptoms in detail: _____

_____

_____

f) Are you currently seeing, or have you ever seen a doctor or healthcare provider for each of the bodily injuries or symptoms listed above? Yes ___ No ___

If Yes, please list all doctors you have seen for treatment of any of the bodily injuries you have listed above.

Provider Name and Address	Condition Treated	Approximate Dates of Treatment

g) Were you hospitalized at any time for the bodily injuries you listed above?

Yes ___ No ___

If Yes, please provide the following:

Hospital Name and Address	Condition Treated	Approximate Dates of Treatment

11) Are you making a claim for lost wages or lost earning capacity?

Yes ___ No ___

If Yes, state the annual gross income you derived from your employment for each year, beginning five years prior to the implantation of the Cook Biodesign® or Surgisis® product(s) until the present:_____

_____

_____

12) Are you making a claim for lost out-of-pocket expenses? Yes ___ No ___

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

_____

_____

13) Has anyone filed a loss of consortium claim in connection with your lawsuit regarding the Cook Biodesign® or Surgisis® product(s)?

Yes ___ No ___

If Yes, identify by name and address the person who filed the loss of consortium claim, state the relationship of that person to you, and state the nature of the claim:_____

_____

14) Please indicate whether the consortium plaintiff is alleging any of the claimed damages set forth below and itemize the alleged damages/expenses:

Claims	Yes/No	Itemized Damages/Expenses
Loss of services of spouse		
Impaired sexual relations		
Lost wages/lost earning capacity		
Lost out-of-pocket expenses		
Physical injuries		
Psychological injuries/emotional injuries		
Other		

15) Please list the name and address of any healthcare providers the consortium plaintiff has seen for treatment for any physical, emotional, or psychological injuries or symptoms alleged to be related to the loss of consortium claim:_____

_____

_____

16) Have you or anyone acting on your behalf had any communication, oral or written, with any of the defendants or their representatives, other than your attorneys?

Yes ___ No ___ Don't Know ___

If Yes, set forth the date of the communication, the method of communication, the name of the person with whom you communicated, and the substance of the communication between you and any defendants or their representatives:_____

III. MEDICAL BACKGROUND

1) Provide your current age: _____Height _____ Weight

2) At the time you received the Cook Biodesign® or Surgisis® product(s), please state:

   Your age _____ Your approximate weight _____

3) State number of vaginal births you have had? _____

4) State the number of cesarean section births you have had? _____

5) In chronological order, list any and all surgeries, procedures, or hospitalizations you had in the 10 year period BEFORE implantation of the Cook Biodesign® or Surgisis® product(s); identifying by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved with each surgery or procedure; and providing the approximate date(s) for each:

Approximate Date	Description of Surgery of Hospitalization	Doctor or Healthcare Provider Involved (including address)

[Attach additional sheets as necessary to provide the same information for any and all surgeries leading up to implantation of the Cook Biodesign® or Surgisis® product(s)]

6) In chronological order, list any and all surgeries, procedures, or hospitalizations you had AFTER the implantation of the Cook Biodesign® or Surgisis® product(s); identifying by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved with each surgery or procedure; and provide the approximate date(s) for each:

Approximate Date	**Description of Surgery of Hospitalization**	**Doctor or Healthcare Provider Involved (including address)**

7) To the extent not already provided in the charts above, provide the name, address, and telephone number of every doctor, hospital, or other health care provider from which you have received medical advice and/or treatment for the past 10 years:

Name and Specialty	**Address**	**Approximate Dates/Years of Visits**

8) Please describe your physical activities associated with daily living, physical fitness, household tasks, and employment-related activities before the implantation of the Cook Biodesign® or Surgisis® product(s).

_____

_____

9) Please describe your physical activities associated with daily living, physical fitness, household tasks, and employment-related activities after the implantation of the Cook Biodesign® or Surgisis® product(s).

_____

_____

10) To the best of your knowledge, have you suffered from any of the following:

a) Adhesions Yes ___ No ___

c) Bleeding or clotting disorders Yes ___ No ___

d) Bowel Obstruction Yes ___ No ___

e) Bowel Perforation Yes ___ No ___

f) Cancer Yes ___ No ___

If yes, specify type and location_____

g) Chronic Constipation Yes ___ No ___

j) Collagen Disorder/Deficiency Yes ___ No ___

k) Connective Tissue Disorder Yes ___ No ___

l) Crohn's Disease, Irritable Bowel Syndrome, Ulcerative Colitis or Chronic Diarrhea Yes ___ No ___

If Yes, please explain which condition and treatment prescribed _____

m) Cystocele Yes ___ No ___

n) Diabetes Yes ___ No ___

o) Diverticulitis Yes ___ No ___

p) Dyspareunia Yes ___ No ____

q) Enterocele Yes ___ No ___

r) Fistulas Yes ___ No ___

s) Hernias Yes ___ No ___

t) Hypertension or High Blood Pressure Yes ___ No ___

u) Hypotension or Low Blood Pressure Yes ___ No ___

v) Immune System Disease or Dysfunction including HIV/AIDS Yes ___ No ___

If Yes, specify disease/dysfunction:_____

x) Malnutrition Yes ___ No ___

y) Muscle or Muscle-Wasting Disorder Yes ___ No ___

If Yes, specify disorder: _____

z) Neuromuscular Disease or Disorder Yes ___ No ___

If Yes, specify disease/disorder:_____

aa) Obesity Yes ___ No ___

cc) Pelvic Trauma Yes ___ No ___

If Yes, describe the nature of the trauma you experienced:_____

dd) Pelvic Tumors or Fibroids Yes ___ No ___

ee) Peritonitis/Sepsis Yes ___ No ___

ff) Rectocele Yes ___ No ___

gg) Recurrent or Chronic vaginal or bladder infections Yes ___ No ___

Specify location and nature of infection: _____

hh) Recurrent Vaginal Pain Yes ___ No ___

If Yes, describe the nature of the vaginal pain you experienced:_____

ii) Urinary Incontinence Yes ___ No ___

jj) Urinary Retention Yes ___ No ____

kk) Uterine Prolapse Yes ___ No ____

mm) Vaginal Vault Prolapse Yes ___ No ___

nn) Wound healing problems Yes ___ No ___

oo) Any other disease of the gut, intestines, or bowel Yes ___ No ___

If Yes, specify condition:_____

* * * * * * * * * * * * * * *

THE FOLLOWING QUESTIONS ARE CONFIDENTIAL AND SUBJECT TO THE PROTECTIVE ORDER APPLICABLE TO THIS CASE.

jj) Were you diagnosed with and/or treated for Sexually Transmitted Diseases for the five year period prior to the implantation of the Cook Biodesign® or Surgisis® product(s) through the present? Yes ___ No ___

If Yes, specify the disease, date of onset, medication/treatment, treating physician and current status of condition:_____

_____

_____

kk) Have you been diagnosed with and/or treated for any alcohol or chemical dependency for the one year prior to the implantation of the Cook Biodesign® or Surgisis® product(s) through the present? Yes ___ No ___

If Yes, specify type and time period of dependency, type of treatment received, name of treatment provider, and current status of condition: _____

_____

_____

ll) Have you experienced, been diagnosed with or been treated for any mental health conditions including depression, anxiety or other emotional or psychiatric disorders in the 5 year period before implantation of the Cook Biodesign® or Surgisis® product(s). Yes ___ No ___

If Yes, specify condition, date of onset, medication/treatment, treating physician and current status of condition:_____

_____

_____

* * * * * * * * * * * * * * *

11) Have you experienced menopause? Yes ___ No ___

If Yes, at what age did it begin?_____

12) Have you undergone vaginal estrogen therapy, hormone therapy, or systemic estrogen replacement therapy (ERT)? Yes ___ No ___

If Yes, please provide the type of therapy you received, date(s) of the therapy, and the name and address of the healthcare provider providing the therapy.

13) Do you now or have you ever smoked tobacco products? Yes ___ No ___

If Yes:

a) How long have/did you smoke?_____

15) List each prescription medication you have taken for more than 3 months at a time, within the last 5 years prior to implant, giving the name and address of the pharmacy where you received/filled the medication, the reason you took the medication, and the approximate dates of use.

Medication and Dosage	**Pharmacy (Name and Address)**	**Reason for Taking Medication**	**Approximate Date(s) of Use**

IV. INSURANCE INFORMATION

1) Provide the following information for any past or present medical insurance coverage within the last 10 years:

Insurance Company (Name and Address)	Policy Number	Name of Policy Holder/Insured (if different than you)	Approximate Dates of Coverage

2) Have you ever been denied life insurance for reasons relating to your health? Yes ___ No ___ Don't Know ____

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

_____

_____

3) To the best of your knowledge, have you been approved to receive or are you receiving Medicare benefits due to age, disability, condition or any other reason or basis?

Yes ___ No ___

If Yes, please specify the following:

a) The date on which you first became eligible:_____

[Please note: if you are not currently a Medicare-eligible beneficiary, but become eligible for Medicare during the pendency of this lawsuit, you must supplement your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C. 1395y(b)(8), also known as Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 and 42 U.S.C. 1395y(b)(2) also known as the Medicare Secondary Payer Act.]

V. PRIOR CLAIM INFORMATION

1) Have you filed a lawsuit or made a claim in the last 10 years, other than in the present suit relating to any bodily injury?

Yes ___ No ___

If Yes, please specify the following:

a) Court in which suit/claim filed or made:_____

b) Case/Claim Number:_____

c) Nature of Claim/Injury:_____

2) Have you applied for workers' compensation (WC), Social Security disability (SSI or SSD) benefits, or other state or federal disability benefits within the past 10 years?

Yes ___ No ___

If Yes, please specify the following:

a) Date (or year) of application:_____

b) Type of benefits sought_____

c) Agency/Insurer from which you sought the benefits:_____

d) The nature of the claimed injury/disability: _____

e) Whether the claim was accepted or denied:_____

VI. FACT WITNESSES

1) Please identify all persons who you believe possess information concerning your injury(ies) and current medical conditions, other than your healthcare providers, and please state their name address and his/her/their relationship to you:

Name	Address	Relationship to You	Information you Believe Person Possesses

VII. IDENTIFICATION OF DOCUMENTS AND OTHER ELECTRONICALLY STORED INFORMATION

For the period beginning three years prior to implantation of the Cook Biodesign® or Surgisis® product(s), please identify all research, including on-line research, you have conducted prior to implantation of the Cook Biodesign® or Surgisis® product(s) regarding the subjects of this litigation, including the implantation of Cook Biodesign® or Surgisis® product(s), the injuries and/or damages you claim resulted from the implantation of Cook Biodesign® or Surgisis® product(s), or your medical or physical condition. Identify date, time, and source,

including any websites visited. Research conducted to understand the legal and strategic advice of your counsel is not considered responsive to this request.

VIII. DOCUMENT REQUESTS

1) DOCUMENTS. State whether you have any of the following documents in your possession, custody, and/or control. If you do, please provide a true and correct copy of any such documents with this completed Fact Sheet.

a) If you were appointed by a court to represent the plaintiff in this lawsuit, produce any documents demonstrating your appointment as such.

i. Not Applicable _____

ii. The documents are attached _____[OR] I have no documents_____

b) If you represent the estate of a deceased person in this lawsuit, produce a copy of the decedent's death certificate and autopsy report (if applicable).

i. Not Applicable _____

ii. The documents are attached _____[OR] I have no documents_____

c) Produce any communications (sent or received) in your possession, which shall include materials accessible to you from any computer on which you have sent or received such communications, concerning the Cook Biodesign® or Surgisis® product(s) or subject litigation, including but not limited to all letters, e-mails, blogs, Facebook posts, tweets, newsletters, etc. sent or received by you. Research conducted to understand the legal and strategic advice of your counsel is not considered responsive to this request.

i. Not Applicable _____

ii. The documents are attached _____[OR] I have no documents_____

d) Produce all documents (including journal entries, lists, memoranda, notes, diaries), photographs, video, DVDS or other media, including all copies,

discussing or referencing the subjects of this litigation including the Cook Biodesign® or Surgisis® product(s), the injuries and/or damages you claim resulted from the Cook Biodesign® or Surgisis® product(s), or evidencing your physical condition from three years prior to the implantation of Cook Biodesign® or Surgisis® product(s) to present, including but not limited to the injuries for which you claim relief in this lawsuit. Research conducted to understand the legal and strategic advice of your counsel is not considered responsive to this request.

i. Not Applicable _____

ii. The documents are attached _____[OR] I have no documents_____

e) Produce any Cook Biodesign® or Surgisis® product packaging, labeling, advertising, or any other Cook Biodesign® or Surgisis® product product-related items in your possession, custody or control.

i. Not Applicable _____

ii. The documents are attached _____[OR] I have no documents_____

f) Produce all documents concerning any communication between you and the Food and Drug Administration (FDA) or between you and any employee or agent of the Defendants, regarding the Cook Biodesign® or Surgisis® product(s) at issue, except as to those communications which are attorney client/work product privileged.

i. Not Applicable _____

ii. The documents are attached _____[OR] I have no documents_____

g) Produce all documents in your possession, custody or control evidencing or relating to any correspondence or communication between Cook Medical

Incorporated, Cook Biotech Incorporated, or any of their related companies or divisions and any of your doctors, healthcare providers, and/or you relating to the Cook Biodesign® or Surgisis® product(s), except as to those communications which are attorney client/work product privileged.

i. Not Applicable _____

ii. The documents are attached _____[OR] I have no documents_____

h) Produce any and all documents in your possession, custody or control reflecting, describing, or in any way relating to any instructions or warnings you received prior to implantation of any Cook Biodesign® or Surgisis® product(s) concerning the risks and/or benefits of your surgery, including but not limited to any risks and/or benefits associated with the Cook Biodesign® or Surgisis® product(s).

i. Not Applicable _____

ii. The documents are attached _____[OR] I have no documents_____

i) Produce any and all documents reflecting the model number and lot number of the Cook Biodesign® or Surgisis® product(s) you received.

i. Not Applicable _____

ii. The documents are attached _____[OR] I have no documents_____

j) If you underwent surgery to remove in whole or in part the Cook Biodesign® or Surgisis® product(s) that you received: produce any and all documents in your possession, custody or control aside from documents that may have been generated by experts retained by your counsel for litigation purposes, relating to any evaluation of the Cook Biodesign® or Surgisis® product(s) and any other material that was (were) surgically removed from you.

i. Not Applicable _____

ii. The documents are attached _____[OR] I have no documents_____

k) If you claim lost wages or lost earning capacity, copies of your federal and state tax returns for the two years prior to implantation of the Biodesign® or Surgisis® product(s) to the present.

i. Not Applicable _____

ii. The documents are attached _____[OR] I have no documents_____

l) All documents in your possession, custody or control concerning payment by Medicare on the injured party's behalf relating to the injuries claimed in this lawsuit, including but not limited to Interim Conditional Payment summaries and/or estimates prepared by Medicare or its representatives regarding payments made on your behalf for medical expenses relating to the subject of this litigation.

i. Not Applicable _____

ii. The documents are attached _____[OR] I have no documents_____

[Please note: if you are not currently a Medicare-eligible beneficiary, but become eligible for Medicare during the pendency of this lawsuit, you must supplement your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C. 1395y(b)(8), also known as Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 and 42 U.S.C. 1395y(b)(2) also known as the Medicare Secondary Payer Act.]

VERIFICATION

I, _____, declare under penalty of perjury subject to all applicable laws, that I have carefully reviewed the final copy of this Plaintiff Fact Sheet dated _____ and verified that all of the information provided is true and correct to the best of my knowledge, information and belief.

_____

Signature of Plaintiff

VERIFICATION OF LOSS OF CONSORTIUM

I, _____, declare under penalty of perjury subject to all applicable laws, that I have carefully reviewed the final copy of this Plaintiff Fact Sheet dated _____ and verified that all of the information provided is true and correct to the best of my knowledge, information and belief.

_____

Signature of Consortium Plaintiff

EXHIBIT 3

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

In re: Cook Medical, Inc. Pelvic Repair System Products Liability Litigation	))	MDL No. 2440

THIS DOCUMENT RELATES TO ALL CASES

DEFENDANTS' FACT SHEET

For each case, the Cook Defendants must complete this Fact Sheet in accordance with the schedule established by Court's Pretrial Order # 7.

I. CASE INFORMATION

This defendant fact sheet pertains to the following case:

Case Name:

Case Number:

II. CONTACTS WITH TREATING AND EVALUATING PHYSICIANS

Plaintiff has identified each physician who treated and/or evaluated plaintiff for pelvic organ prolapse, stress or urinary incontinence, and/or associated conditions that led to the use of defendants' Biodesign® or Surgisis® products. As to each such physician, provide the following information:

A. CONSULTATION AND OTHER NON-SALES REPRESENTATIVE CONTACTS

As to each identified physician with whom the defendants were affiliated, consulted or otherwise had contact outside the context of sales representative contacts, set forth the following:

1. Identify the physician.

2. Identity and title of each of defendants' employees who had such contact with the physician.

3. Dates of contact/affiliation with physician.

4. Nature of the contact/affiliation with physician.

5. Set forth any monetary and/or non-monetary benefits, including but not limited to money, travel, and device samples, provided to the physician by any agent of any named defendant, including amounts, dates, and purpose.

6. For any device manufactured by any named defendant, set forth any training provided to or by the physician; including but not limited to date, location, physician's role, cost for attending such training, and subject matter.

7. List any written agreements, contracts, letters, memoranda, or other documents setting forth the terms or nature of any contact or affiliation with the physician; this includes but is not limited to any agreements to research or otherwise study any named defendant's products.

8. For each facility where the physicians were associated, set forth the number and type of Biodesign® or Surgisis® products purchased from you.

9. Set forth any contact between the defendants and the physician with regard to the plaintiff, this includes but is not limited to any information or knowledge defendants have with respect to research studies conducted on or that include information related to plaintiff's implant or associated lot number.

10. Set forth all information provided by the physician to the defendants with regard to the safety, use, or efficacy of the defendants' product(s).

B. SALES REPRESENTATIVE CONTACTS

As to each sales representative who had any contact with an identified physician, set forth the following:

1. Identity of physician.
2. Identity and last known address and telephone number of sales representative.
3. The work history, with you, and current relationship, if any, between the specified defendant(s) and the sales representative.
4. Identity of the sales representative's supervisor(s) during his/her employment.
5. Identify all district and/or regional sales managers who were responsible for the management of the sales representatives identified in your response to Number 2 above, and their current relationship, if any, with Cook.
6. Set forth all information provided by the physician to the sales representative, with regard to the plaintiff.
7. Set forth the date and location of each operation or procedure performed on the plaintiff, which was attended at all by the sales representative.
8. State whether the sales representative, while employed by you, has ever been investigated, reprimanded, and/or otherwise penalized by any person, entity, or government agency for his/her sales or marketing practices, and if so set forth the details thereof.

III. INFORMATION REGARDING THE PLAINTIFF

A. Identify all data, information, objects, and reports in defendants' possession or control or which have been reviewed or analyzed by defendants, with regard to the plaintiff's medical condition; this also includes but is not limited to any study or research that includes

plaintiff's specific implant or associated lot number. Attorney-work product is specifically excluded from this request.

B. Identify any direct or indirect contact, either written or oral, between the plaintiff and any employee or representative of the defendants, including but not limited to pre-operative inquiries, and post-operative complaints. This request specifically includes, but is not limited to, calls to the M.S.&S. hotline and calls to the Field Assurance Department.

C. Identify all Med Watch Adverse Event Reports and/or any other documents submitted to the FDA or any other government agency with regard to the plaintiff.

D. If you have any evidence or records indicating or demonstrating the possibility that any person, entity, condition, or product, other than the defendants and their product(s), is a cause of the plaintiff's injuries, ("Alternate Cause") set forth:

1. Identify the Alternate Cause with specificity.

2. Set forth the date and mechanism of alternate causation.

IV. MANUFACTURING INFORMATION

A. Identify the lot number(s) for the device(s) implanted into the plaintiff.

B. Identify the lot number(s) for the device(s) used to implant the defendant's device(s) into the plaintiff.

C. Identify the location and date of manufacture for each lot set forth in response to A and B above.

D. Identify the date of shipping and sale, and the person or entity purchasing, each of plaintiff's device(s).

E. Identify all manufacturing facilities and associated lot number(s) of plaintiff's implanted device(s), including but not limited to all trocars and any other surgical devices or means of implantation included or sold with plaintiff's implant(s).

V. DOCUMENTS

Please ensure that the production of documentation includes specific reference to the question to which the documentation is provided in response. Documentation is defined to include all forms of documents, including but not limited to paper, email, video, audio, spreadsheets, or otherwise.

A. Identify and attach complete documentation of all information set forth in I through IV above; except, you may identify but not serve copies of medical records that were provided to defendants by plaintiff's counsel.

B. Aside from any privileged materials, identify and attach all records, documents, and information that refer or relate to the plaintiff in defendants' possession or control, to the extent not identified and attached in response to a prior question.

C. Produce a true and complete copy of the Device History Record for the Plaintiff's lot number(s).

D. Produce a true and complete copy of the complaint file relating to the Plaintiff.

E. All call notes, detail notes, call summaries, entries made by sales representatives into any database or e-room, laptop or other computer or handheld device, hard copy documents, emails, and/or notes or records or summaries of calls, contacts and/or communications of any kind regarding each implanting or treating physician during the relevant time period.

VERIFICATION

_____, being first duly sworn upon his oath, deposes and says:

That I am an authorized agent of Cook and that I verify the Defendants' Response to Plaintiff's Fact Sheet addressed to the Cook Defendants in In Re Cook Medical, Inc. Pelvic Repair Systems Products Liability Litigation, MDL No. 2440 (S.D. W. Va.), and that the matters stated therein are not the personal knowledge of deponent; that the facts stated therein have been assembled by authorized employees and counsel of Cook and deponent is informed that the facts stated therein are true. I hereby certify, in my authorized capacity as an agent for Cook, that the responses to the aforementioned Defendants' Fact Sheet are true and complete to the best of Cook's knowledge.

_____
Cook
Title

SUBSCRIBED and SWORN to before me this ____ day of , 20___.

Notary Public

My Commission Expires: