UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

IN RE: PROTON-PUMP INHIBITOR PRODUCTS LIABILITY LITIGATION	:	MDL NO. 2789 Civil Action No. 1:17-MD-2789
	:	JUDGE CLAIRE C. CECCHI

CASE MANAGEMENT ORDER NO. 9
(Plaintiff Fact Sheet and PFS Document Production)

The Court hereby issues the following Case Management Order to govern the form, procedure, and schedule for the completion and service of Plaintiff Fact Sheets ("PFS"), and other documents referenced therein.

I. Scope of Order

This Order applies to all Plaintiffs and their counsel in: (a) all actions transferred to *In Re: Proton-Pump Inhibitor Products Liability Litigation* ("MDL-2789") by the Judicial Panel on Multidistrict Litigation ("JPML") pursuant to its Order of August 2, 2017; (b) all related actions originally filed in or removed to this Court; and (c) any "tag-along" actions transferred to this Court by the JPML pursuant to Rules 6.2 and 7.1 of the Rules of Procedure of the JPML, subsequent to the filing of the final transfer order by the Clerk of this Court (collectively, "Member Actions"). The obligation to comply with this CMO and to provide a PFS shall fall solely to the individual counsel representing a Plaintiff. As with all case-specific discovery, the members of the PSC or PEC are not obligated to conduct case-specific discovery for Plaintiffs by whom they have not been individually retained.

II. Plaintiff Fact Sheets

A. The PFS Form

The form PFS that shall be used in MDL 2789 and all Member Actions is attached hereto as Exhibit A. In accordance with the schedule set forth below, every Plaintiff in each Member Action shall:

1. Complete and execute a PFS;

2. For each Defendant named in the complaint whose PPI product(s) is (or are) identified in the PFS, produce a record showing use of at least one of that Defendant's PPI product(s);

3. Produce requested records and documents in response to the document requests set forth in the PFS as maintained by Plaintiff and his/her counsel (to the extent not subject to privilege and/or work-product protections);

4. Produce duly executed authorizations to obtain discoverable records as described in Section IV. below, using the form authorizations attached to this Order as exhibits;

5. Serve the completed and executed PFS, as well as all documents requested in the PFS and authorizations, upon counsel for each Defendant named in the Member Action in the manner described in Section V. below; and

6. Serve a courtesy copy of the PFS and associated materials upon Plaintiffs' Executive Committee ("PEC") in the manner described in Section V. below.

B. Substantial Completion

1. In completing the PFS, every Plaintiff is required to provide a PFS that is substantially complete in all respects. For a PFS to be "substantially complete in all respects," the responding Plaintiff must: (1) answer the questions contained in the PFS to the best of his or her ability; and (2) comply with items 1-6 set forth in Section II.A. above.

a. Deficiencies. Failure to provide a substantially complete PFS and duly executed authorizations or providing incomplete or deficient information shall be governed by Section II.D. below.

b. Delinquencies. Failure to provide a PFS and duly executed authorizations shall be governed by Section II.E. below.

c. Failure to Provide Record Showing Use of PPI. Failure to produce, for each Defendant named in the complaint whose PPI is (or PPIs are) identified in the PFS, a record that identifies use of at least one of that Defendant's PPI product(s) shall be governed by Section III. below.

C. Amendments & Verification

1. Each Plaintiff shall remain under a continuing duty to supplement the information provided in the PFS pursuant to Fed. R. Civ. P. 26(e).

2. Each completed PFS shall be verified, signed and dated by the Plaintiff or the Plaintiff's representative as if it were interrogatory responses under Fed. R. Civ. P. 33. All responses in a PFS or amendment thereto are binding on the individual Plaintiff as if they were contained in answers to interrogatories under Fed. R. Civ. P. 33 and can be used for any purpose and in any manner that answers to interrogatories can be used pursuant to the Federal Rules of Civil Procedure, subject to the confidentiality provisions of Section VII. below. The Requests for Production of Documents in the PFS shall be treated as document requests under Fed. R. Civ. P. 34.

3. The questions in the PFS shall be answered without objection as to relevance or the form of the question.

D. Fact Sheet Deficiency Dispute Resolution

1. Phase I: Deficiency Letter

a. If a Defendant deems a PFS deficient, Defendant's counsel shall notify Plaintiff's attorney of record of the purported deficiencies in writing via email and allow

such Plaintiff an additional thirty (30) days to correct the alleged deficiency. A courtesy copy of the email shall be sent via email to the PEC's designee at ppipfsdeficiency@weitzlux.com.

b. Defendant's email communication shall identify the case name, docket number, and thirty (30) day deadline date and include sufficient detail regarding the alleged deficiency(ies).

2. **Phase II: Meet & Confer**

Should a Plaintiff not respond to the deficiency letter within the time required, as set forth in Section II.D.1. above, then the Defendant may request a meet and confer. Defendant's counsel shall notify Plaintiff's attorney of record in writing via email of the request to meet and confer and state that the meet and confer shall occur within fourteen (14) days. A courtesy copy of the email shall be sent via email to the PEC's designee at ppipfsdeficiency@weitzlux.com. The parties' meet and confer period shall begin upon receipt of the email by Plaintiff's attorney of record and, absent agreement of the parties, shall be completed by the conclusion of the fourteen (14) days.

3. **Phase III: Motion to Compel**

a. Following the meet and confer period, should the individual Plaintiff: (i) fail to cure the stated deficiency(ies); (ii) fail to assert objections to same; (iii) fail to respond to or participate in the meet and confer process; or (iv) otherwise fail to provide responses (including the requested documents and/or signatures), and absent agreement of the parties to further extend the period for meeting and conferring, at any time following expiration of the fourteen (14) day meet and confer period, Defendant may then file a Motion to Compel the allegedly deficient discovery information.

b. Any such filing shall be via ECF, with a courtesy copy via email to Plaintiff's attorney of record and via email to the PEC's designee at ppipfsdeficiency@weitzlux.com.

c. Any motion to compel pursuant to this CMO need not be noticed for presentment as required by Local Rule 7.1.

d. Any response to such a motion shall be filed and served within fourteen (14) days following the date of service. Any reply, if necessary, shall be filed within seven (7) days following the date of service of the opposition.

e. Absent an Order from the Court granting a request by either or both parties for oral argument, the Court will rule on such motions without hearing argument.

E. Failure to Serve a PFS

1. Each Plaintiff may request one extension of thirty (30) days to serve a completed PFS, which Defendants shall not unreasonably withhold. Such requests must be made in writing via email to Defendants' counsel before the expiration of the deadline, with a courtesy copy the PEC's designee at ppipfsextension@weitzlux.com.

2. Phase I: Notice of Non-Compliance

a. Should any Plaintiff fail to serve an executed PFS within the time required in this CMO, including Section II.E.1., above, Defendant(s) shall send a Notice of Non-Compliance letter via email to that Plaintiff's attorney of record, with a courtesy copy via email the PEC's designee at ppipfsmotion@weitzlux.com.

b. Following receipt of the Notice of Non-Compliance, the Plaintiff shall have twenty one (21) days to serve the PFS.

3. **Phase II: Meet & Confer**

Should a Plaintiff not respond to the Notice of Non-Compliance within the time required in Section II.E.2.b. above, then the Defendant may request a meet and confer. Defendant's counsel shall notify Plaintiff's attorney of record in writing via email of the request to meet and confer and state that the meet and confer shall occur within fourteen (14) days. A courtesy copy of the email shall be sent via email to the PEC's designee at ppipfsmotion@weitzlux.com. The parties' meet and confer period shall begin upon receipt of the email by Plaintiff's attorney of record and, absent agreement of the parties, shall be completed by the conclusion of the fourteen (14) days.

4. **Phase III: Motion to Compel**

a. Should a Plaintiff fail to provide an executed PFS following the time period allowed in Section II.E.2.b. above, Defendant(s) may then move the Court for a motion to compel via ECF, with a courtesy copy via email to Plaintiff's attorney of record and via email to the PEC's designee at ppipfsmotion@weitzlux.com.

b. Any motion to compel pursuant to this CMO need not be noticed for presentment as required by Local Rule 7.1.

c. Absent an Order from the Court granting a request by either or both parties for oral argument, the Court will rule on such motions without hearing argument.

III. Stage 1 and Stage 2 Categorization

A. Obligation to Produce Defendant Fact Sheet. A separate Case Management Order will be entered to govern the Defendant Fact Sheet ("DFS") process. That order shall require each Defendant named in a complaint to serve a completed DFS on each Plaintiff's counsel identified in the PFS once a PFS is "substantially complete in all respects" with respect to that

Defendant (as set forth in Section II.B.1. above), including that the Plaintiff must provide a record (in addition to the PFS, and consisting of more than just a declaration or affidavit by the Plaintiff) indicating that he or she used at least one of that Defendant's PPI products. Defendants shall not be obligated to produce a DFS for any case in which a Plaintiff or his/her counsel has not provided a record that identifies the Plaintiff's use of at least one of that Defendant's PPI products. Defendants shall not challenge the adequacy (*i.e.*, the qualitative reliability) of the record(s) as a basis for refusing to produce a DFS.

B. Categorization of Claims into Stage 1 or Stage 2 Claims. Once a Plaintiff has produced a record (in addition to the PFS, and consisting of more than just a declaration or affidavit by the Plaintiff) with respect to a Defendant, the Plaintiff's claims against that Defendant will be categorized as "Stage 1 Claims" with respect to that Defendant. If a Plaintiff has not produced such a record with respect to at least one of a Defendant's PPI products, Plaintiff's claims against that Defendant will be categorized as "Stage 2 Claims" with respect to that Defendant. If a Plaintiff has produced such record(s) with respect to every Defendant named in the complaint, the case shall be deemed a Stage 1 Case in its entirety ("a Stage 1 Case"); if a Plaintiff has not produced record(s) with respect to any Defendant named in the complaint, the case shall be deemed a Stage 2 Case in its entirety ("a Stage 2 Case"). In a case with multiple Defendants, a Plaintiff's claims may be categorized as Stage 1 Claims with respect to one Defendant, but could be categorized as Stage 2 Claims with respect to another Defendant(s) ("a Mixed Stage 1 / Stage 2 Case").

C. Potential Re-Categorization of Cases. A case may move from a Stage 2 Case to a Stage 1 Case (or from a Mixed Stage 1 / Stage 2 Case to a Stage 1 Case) at any time if the Plaintiff: (1) produces a record, as to each named Defendant, that identifies use of the

Defendant's PPI product; or (2) dismisses each Defendant for whom the Plaintiff elects not to and/or cannot produce such a record. This production (or dismissal) may come after service of a PFS.

D. Further Discovery. A Stage 1 Case may proceed to any further case-specific discovery only upon the entry of a subsequent Case Management Order addressing such discovery. A Stage 2 Case or a Mixed Stage 1 / Stage 2 Case may not be the subject of further Plaintiff-specific discovery. A case may remain as a Stage 2 Case or a Mixed Stage 1 / Stage 2 Case until further order of this Court.

IV. Authorizations

A. Execution of Authorizations Generally. Plaintiffs shall sign the Authorizations listed below without: (1) setting forth the identity of the applicable custodian of the records or provider of care, or (2) dating the authorizations. Plaintiff's counsel shall retain the signed but otherwise blank authorizations, which shall be used as described herein.

B. Authorizations to be Provided.

1. Medical Authorizations. Each individual Plaintiff shall provide to Plaintiff's counsel sufficient originals of the "Limited Authorization to Disclose Health Information" attached as Exhibit B to enable Plaintiff's counsel to provide to Defendants a completed authorization for each health care provider listed in the PFS. Plaintiff's counsel also shall maintain at least ten additional blank authorizations in the event Defendants request records from additional providers.

2. Three Blank Psychological Injury Authorizations. If a Plaintiff is asserting a claim for psychological injury (beyond that which ordinarily accompanies a physical injury), such Plaintiff also shall provide to Plaintiff's counsel three blank Authorizations attached

as Exhibit C. If a Plaintiff is not asserting a claim for psychological injury, Plaintiff does not need to complete the Authorization attached as Exhibit C.

3. Three Blank Employment Authorizations. If a Plaintiff is asserting a claim for lost wages, then such Plaintiff shall provide to Plaintiff's counsel three originals of the Authorization for the release of employment records, in the form attached as Exhibit D.

4. Three Blank Insurance Authorizations. Each individual Plaintiff who has had health insurance of any kind in the past 12 years shall provide to Plaintiff's counsel three originals of the Authorization for the release of insurance records, in the form attached as Exhibit E. If the Plaintiff has been covered by Medicare at any time in the past 12 years, such Plaintiff also shall provide to Plaintiff's counsel the Authorization for the release of Medicare records, in the form attached as Exhibit F.

5. Workers' Compensation and Disability Authorizations. If a Plaintiff has applied for or been awarded workers' compensation or disability benefits at any time in the past 12 years, such Plaintiff also shall provide to Plaintiff's counsel the Authorization for the release of workers' compensation records, in the form attached as Exhibit G, and/or the Authorization for the release of disability records, in the form attached as Exhibit H, as applicable. If a Plaintiff has not applied for or been awarded either workers' compensation or disability, that Plaintiff need not complete either Authorization.

6. OTC Program Authorizations. Each Plaintiff who has belonged to a loyalty, rewards, or credit card program with a warehouse club, wholesale outlet, retail store, or pharmacy from which the Plaintiff purchased over-the-counter ("OTC") PPI products shall provide to Plaintiff's counsel an Authorization for the release of records from each such program, in the form attached as Exhibit I.

C. Records Custodians Not Listed in PFS. For any custodian of records not listed in the Plaintiff's Fact Sheet, Defendants may request that Plaintiff's counsel complete a blank Authorization so that Defendants may obtain records from that custodian (which such request may be made by Defendants' medical records collection vendor). Plaintiffs' counsel must provide such authorizations within fourteen (14) days of the written request. If Plaintiff's counsel objects to the use of the Authorization to obtain records from the source identified in the request, Plaintiffs' counsel must assert that objection within 14 days. Following the 14-day period, if Plaintiff's counsel objects or has not responded, Plaintiff's counsel and Defendants' counsel shall meet and confer in an attempt to resolve the objection. If counsel are unable to resolve the objection, or if Plaintiff's counsel does not respond to Defendants' attempt to meet and confer, Defendants may file a motion to compel. Plaintiffs' counsel shall have fourteen (14) days to file any opposition.

D. Obligation to Cooperate by Providing Additional Authorizations. If Defendants wish to obtain records from a custodian of records who will not accept the authorizations in the form that Plaintiff executed pursuant to this Order, or if Plaintiffs' counsel runs out of signed but otherwise blank authorizations, Plaintiff will cooperate with Defendants and provide the necessary authorization(s). If Plaintiffs' counsel objects to the use of a particular authorization, the procedures established in Section II.D. shall apply.

V. Service and Timing of the PFS and Related Materials

A. Cases Currently Pending in This District. Each Plaintiff in a Member Action that is pending in the District of New Jersey on the date of entry of this Order shall have 120 days from same to serve their fully executed PFS and duly executed authorizations, with the relevant documentation, as set forth in Section II.A.

B. Cases Filed in or Transferred to This District After the Entry of This Order. Each Plaintiff in a Member Action that is not pending in the District of New Jersey on the date of entry of this Order but thereafter becomes part of this MDL- 2789 shall have ninety (90) days from the date of service of the first Short Form Answer received and filed by a Defendant to serve their PFS and duly executed authorizations with the relevant documentation attached, as set forth in Section II.A.

C. Transmission of PFS and Other Documents to Defendants. Plaintiffs shall complete and serve their PFS and documents responsive to the requests for production of documents set forth therein upon Defendants by uploading them to a global ShareFile site that counsel for all parties can access maintained by The Marker Group at https://tmg-data.com/ (See Exhibit J for specific access instructions). Medical, pharmacy and insurance records shall be produced as searchable PDFs[1] with each facility's or provider's records contained in a separate PDF. All other documents, if any, shall be produced in the format set forth in the ESI Order (Doc. 73). Uploading to the global ShareFile site in the aforementioned manner shall constitute effective service of the PFS and such records.

D. Transmission of Courtesy Copies to Plaintiffs' Leadership. Concurrent with service to Defendant, Plaintiffs shall serve a courtesy copy of the completed PFS and authorizations upon the PEC by emailing them to the PEC designee, at ppipfsservice@weitzlux.com.

E. Additional Defendants. As additional defendants are named in this MDL, they will be added, as necessary, to this order, given access to the global ShareFile site, and/or notice shall be provided to the PSC by contacting PEC designee, at ppipfsservice@weitzlux.com.

[1] Endorsement of such records with Bates-numbers is strongly encouraged, in the following format: a combination of an alpha prefix containing Plaintiff's initials and the facility or provider name along with an 8-digit number and to be numerically sequential for each facility or provider (*e.g.* JD_Memorial_Hospital_00000001).

VI. Voluntary Dismissals

This Order shall in no way prohibit or inhibit a Plaintiff's counsel from filing voluntary requests for dismissals of a specific defendant or defendants, or of an entire Plaintiff's case, for those Plaintiffs who are unable to comply with the requirements set forth in this Order.

VII. Confidentiality

All information disclosed in a PFS, the PFS itself, and all related documents (including health care records and information) produced pursuant to the PFS or from the authorizations provided therewith shall be deemed confidential and treated as "Confidential Information" as defined in the Protective Order (Doc. 23).

IT IS SO ORDERED, this 5 th day of February 2018.

HON. CLAIRE C. CECCHI
UNITED STATES DISTRICT JUDGE

EXHIBIT A

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY
NEWARK DIVISION

IN RE: PROTON PUMP INHIBITOR PRODUCTS LIABILITY LITIGATION (NO. II)	**2:17-md-2789 (CCC)(MF) (MDL 2789)**
	PLAINTIFF FACT SHEET

Each plaintiff alleging injury from the use of a Proton Pump Inhibitor ("PPI") must complete this Plaintiff Fact Sheet ("PFS"). If you are completing this PFS in a representative capacity for someone who has died or who otherwise cannot complete the PFS, please answer as completely as you can for that person.

In completing this PFS, you are under oath and must provide information that is true and correct to the best of your knowledge, and your answers must be as complete as the information reasonably available to you permits. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect. If you do not have knowledge sufficient to respond fully to a request or question after making a good faith and reasonable effort to obtain the relevant information, you must so state.

The parties, through their counsel, have agreed to limit the scope of the information and documents being requested from plaintiffs at this time to that which is set forth in this PFS.

If you have any documents, including, but not limited to, packaging, labeling, or instructions for any of the PPI products identified in your responses below, materials or items that you are requested to produce as part of answering this PFS, or that relate to the injuries, claims, and/or damages that are the subject of your complaint, you must NOT dispose of, alter, or modify these documents or materials in any way. You are required to give all of these documents and materials to your attorney as soon as possible. If you are unclear about these obligations, please contact your attorney.

The parties, by counsel, agree that Defendants do not waive the right to request additional information or documents by way of a supplemental fact sheet, interrogatories, requests for production of documents, and/or requests for admission. However, any such requests will be permitted only upon a subsequent CMO or other Court order. You have an ongoing duty to supplement the responses to this PFS should you obtain or learn of additional responsive information and/or materials.

This PFS is completed pursuant to the Federal Rules of Civil Procedure. Your responses to the PFS shall be treated as answers to interrogatories and subject to the requirements of the Federal Rules of Civil Procedure and the applicable Local Rules. Information provided in response to this PFS will be used only for purposes related to this litigation and is subject to the Protective Order as entered under Docket Entry No. 23, and may be disclosed only as permitted by the Protective Order in this litigation.

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

I. GENERAL INFORMATION

A. Name of person completing this PFS: _____

B. State the following for the civil action you filed:

1. Case Caption: _____

2. Case No: _____

3. The name of the principal attorney(s) representing you and his/her contact information:

_____
Name

_____
Firm

_____
Address

_____
Telephone Number

_____
E-mail Address

C. If you are completing this PFS in a representative capacity, complete the following:

1. Your name:

_____

2. Your address:

_____
_____

3. The name of the individual or estate you are representing, and in what capacity you are representing the individual or estate:

_____
_____

4. If you were appointed as a representative by a court, the court and date of appointment:

Court: _____

Date or Appointment: _____

5. Your relationship to the plaintiff on whose behalf you are completing this PFS: _____

6. If you represent a decedent's estate, state the date and place of the decedent's death:

a. Date of Decedent's Death: _____

b. Place of Decedent's Death: _____

The remainder of this Fact Sheet requests information about the person who alleges injury from the use of a PPI. If you are completing this PFS in a representative capacity, please respond to the remaining questions with respect to the person who allegedly used the PPI, unless the question instructs you otherwise. Questions using the term "You" refer to the person who allegedly used the PPI, unless instructed otherwise.

II. PERSONAL INFORMATION FOR THE PPI USER

A. Full name (first, middle and last):_____

B. Social Security Number: _____

C. Maiden name or other names used or by which you have been known, and the date(s) you were known by those other names:

_____
_____

D. Current Address: _____
_____

E. How long have you been living at this address? _____

F. List all prior addresses during the last ten (10) years, and the dates when you lived at those addresses:

PRIOR ADDRESS	DATES YOU LIVED AT THIS ADDRESS

G. Date and place of birth: _____

H. Gender: Male_____ Female_____ Prefer to self-identify as: _____

I. Ethnicity: Caucasian (white) _____ Hispanic _____ Black _____
Native American _____ Asian _____ Other (please specify) _____

J. Beginning with high school and continuing through your highest level of education, identify each school, college, university and/or other educational institution you have attended, the dates of attendance, courses of study pursued, and diplomas or degrees awarded:

Name of School	City/State	Degree awarded and/or area of study/major	Approx. Dates of Attendance

K. If you are, or have ever been, married, list for each marriage the name of your spouse and date of marriage:

_____

_____

L. If applicable, does your spouse seek damages for loss of consortium in this lawsuit?

Yes ___ No ____ N/A _____

M. If applicable, for each of your children, list his/her name, age, and current address:

Name	Age	Current Address

N. Employment Information

1. Are you currently employed?

Yes ____ No ____

2. If you are currently employed, please provide the following information regarding your current employer:

Name of Employer: _____
Address: _____
Dates of Employment: _____
Occupation/Job Duties: _____

3. If you are not currently employed, did you leave your last job for a medical reason?

Yes ____ No ____

If yes, describe why you left your last job:

_____

_____

4. Provide the following information for each employer you have had in the last seven (7) years (other than your current employer):

   Name of Employer: _____
   Address: _____
   Dates of Employment: _____
   Occupation/Job Duties: _____
   Salary / Weekly Wage (only if you are making a lost wages or earning capacity claim): _____

5. During the previous five (5) years, have you been out of work for more than thirty (30) days during any calendar year for reasons related to your health?

   Yes ____ No ____

   If yes, please state the date(s), employer, and describe the condition:

   _____

   _____

O. Military Service Information

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

   Yes _____ No _____

2. If yes, state the branch and dates of service:

   _____

3. Were you ever rejected or discharged from the military for any reason relating to your medical or physical condition(s)?

   Yes _____ No _____

4. If yes, state what that condition(s) was.

   _____

P. Insurance/Claim Information

1. Identify each insurance carrier (including government health care programs such as Medicare and Tricare (CHAMPUS)) with whom you

have had health insurance coverage at any time during the past ten (10) years:

Insurance Co.	Policy No.	Policy Holder	Approx. Dates of Coverage

2. Have you filed a worker's compensation, social security, and/or state or federal disability claim within the last ten (10) years?

Yes _____ No _____

If yes, for each claim please state:

a. Type of claim (for example, worker's comp., disability):

_____

b. Year claim was filed: _____

c. The agency(ies) to whom you submitted your application:

_____

d. Court/State where claim was filed: _____

e. Nature of claimed injury/disability: _____

3. Within the past ten (10) years, have you ever received Medicare, Medicaid, DOD Tricare, State Children's Health Insurance Program (SCHIP), Veterans Health Administration (VHA), or Indian Healthcare Services (IHS)?

Yes _____ No _____

a. If yes, please identify the benefits received:

_____

b. If you answered yes, are you receiving those benefits now?

Yes _____ No _____

Q. In the past ten (10) years, have you filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury(ies)?

Yes _____ No _____

If yes, for each such lawsuit or claim, state the party(ies) you sued or made a claim against; the court in which the lawsuit, if any, was filed; the attorney who represented you; a brief description of the injury(ies)/claims asserted; and the outcome of the claim.

_____
_____
_____
_____

R. Have you filed for bankruptcy in the past seven (7) years?

Yes _____ No _____

If yes, identify the court in which the bankruptcy proceeding was filed, the date of the filing, the case number, and the current status:

_____
_____
_____

III. USE OF PROTON PUMP INHIBITOR(S)

A. Identify, by checking the applicable box(es) below, every PPI product you have ever taken, whether prescribed by a healthcare provider, given as a sample by a healthcare provider, or obtained without a prescription (i.e., over the counter ("OTC")):

Dexilant:

☐ Brand Name
☐ Generic (Dexlansoprazole)
☐ Unsure

Nexium:

☐ Brand Name
☐ Generic (Esomeprazole)

☐ Over the Counter (Nexium 24HR)
☐ Unsure

Prevacid:

☐ Brand Name
☐ Generic (Lansoprazole)
☐ Over the Counter (Prevacid 24HR)
☐ Unsure

Prilosec:

☐ Brand Name
☐ Generic (Omeprazole)
☐ Over the Counter (Prilosec OTC)
☐ Unsure

Protonix:

☐ Brand Name
☐ Generic (Pantoprazole)
☐ Unsure

Zegerid:

☐ Brand Name
☐ Generic (Omeprazole + Sodium)
☐ Over the Counter (Zegerid OTC)
☐ Unsure

Other PPI Product:

☐ I took the following PPI product not listed above:

_____

Unknown PPI Product:

☐ I do not know what PPI product I took.

B. For each PPI product you identified in your response to Question III.A., above, state the following, if known:

PPI Product Taken	Approx. Date(s) of Use	Dosage (Ex. 20 mg twice daily)	Reason you were taking the PPI (to the best of your understanding)	Full Name & Address of Prescribing Healthcare Provider (if applicable)	Name & Address of Dispensing Pharmacy (if prescription) or Where Obtained (if OTC)

C. Are you currently taking any PPI product?

Yes _____ No _____

If yes, state the name of the PPI product you are currently taking:

_____

D. Were you given any written instructions, warnings, or other information regarding use of any PPI?

Yes _____ No _____ Unsure _____

1. If yes, state when the written instructions, warnings, or other information regarding the use of the PPI were given and identify each person or entity from whom you received the instructions, warnings or other information:

_____
_____
_____
_____
_____

2. Approximate date: _____

3. Name of person or entity (and address if not otherwise provided):

_____

_____

E. Were you given any oral instructions, warnings, or other information regarding the use of any PPI? Yes _____ No _____ Unsure _____

1. If yes, state when the oral instructions, warnings, or other information regarding the use of the PPI were given and identify each person or entity from whom you received the instructions, warnings, or other information.

2. Approx. date: _____

3. Name of person or entity (and address and telephone number if not otherwise provided): _____

F. Have you had any direct communication, written or oral, with the manufacturer(s) of any of the PPI products you identified above, or any of its representatives?

Yes _____ No _____

If yes, describe each such communication and the approximate date on which it occurred:

_____

_____

_____

G. During the last ten (10) years, or from the date you first used any PPI product, whichever is longer, have you been a member of a loyalty, rewards, or credit card program with a warehouse club, wholesale outlet, retail store, or pharmacy from which you purchased OTC PPI products?

Yes _____ No _____ Unsure _____

If yes, for each such entity, state the following:

1. Name: _____

2. Location (City & State): _____

3. The approximate time period during which you purchased OTC PPIs from this entity: _____

4. Your loyalty or rewards number: _____

H. During the last ten (10) years, or from the date you first used any PPI product, whichever is longer, have you been a member of an on-line retailer or wholesaler of prescription or OTC medications?

Yes _____ No _____

If yes, please identify the website for each such retailer or wholesaler:

_____
_____
_____
_____

IV. INJURIES AND CLAIMS

A. Alleged Injuries

1. Are you claiming that you suffered bodily injury(ies), illnesses, and/or disabilities as a result of your use of the PPI(s) you identified in Section III.A., above?

Yes _____ No _____

2. If yes, provide the information requested below:

a. Identify the injury(ies), illness(es) and/or disability(ies) that you claim is/are related to your use of PPIs:

_____
_____
_____
_____
_____
_____
_____
_____

b. Are the injuries, illnesses or disabilities continuing?

Yes _____ No _____

If yes, explain:

i. How did you first became aware of the injury(ies), illness(es) or disability(ies) described above?

_____
_____
_____
_____

ii. Approximately when did you first become aware of your injury(ies), illness(es) or disability(ies)?

_____
_____

iii. Was the diagnosis of any of the injuries or illnesses described above confirmed with a biopsy?

Yes _____ No _____ Unsure _____

If yes, where and when was the biopsy was performed?

_____
_____
_____

3. Has any physician or other healthcare provider informed you that any injury identified above was caused or contributed to by, or related to, your use of any of the PPI product(s) you claim to have used?

Yes ____ No ____ Unsure ____

If yes, please set forth:

a. the name and address of the physician or other healthcare provider; and

b. the approximate date(s) on which the physician or other healthcare provider so informed you.

_____
_____
_____

4. Do you claim that your use of a PPI worsened an injury or condition that you already have or had in the past?

Yes ____ No ____ Unsure_____

If yes, set forth the injury(ies) or condition(s), and whether or not you had already recovered from that injury(ies) or condition(s) before you took the PPIs.

_____
_____
_____

5. Are you claiming a psychiatric injury or condition as a result of your use of the PPI(s) identified above, beyond the pain and suffering, emotional distress and mental anguish from the underlying claimed physical injury?

Yes _____ No _____

If yes, describe the condition(s) you attribute to your use of the PPI(s) identified above and, if applicable, set forth the name and address of each physician, therapist, mental healthcare provider, or other healthcare provider from whom you have received treatment for such condition(s) and the dates on which treatment was received.

_____
_____
_____
_____

6. If you are claiming a psychiatric injury or condition as a result of your use of the PPI(s) identified above, state whether you experienced or have been treated for that injury or condition prior to your use of a PPI.

Yes _____ No _____

If yes, state:

a. Name and address of each healthcare and/or mental healthcare provider who treated you:

_____
_____

b. Condition(s) for which treated:

_____
_____

c. When treated: _____

d. Medication(s), if any, prescribed for such condition(s):

_____

_____

e. Do you claim that your PPI use aggravated an existing psychiatric injury or condition(s) for which treatment was sought and for which you are seeking damages in this lawsuit?

Yes _____ No _____

If yes, set forth the name and address of each physician, therapist, mental healthcare provider, or other healthcare provider from whom you received treatment for such injury(ies)/condition(s) and the dates on which treatment was received.

_____

_____

_____

_____

B. Claims / Damages Alleged

1. Where were you living (city and state/country) when you were first diagnosed with your claimed injury based upon the allegations in your complaint?

_____

2. Are you claiming that you lost earnings or impairment of earning capacity as a result of any injury(ies)/condition(s) you contend was/were caused by your use of PPIs?

Yes _____ No _____

If yes:

a. State the approximate total amount of time you have lost from work as a result of any injury(ies)/condition(s) you claim or believe was/were caused by your use of PPIs, and the amount of income you lost.

_____

_____

_____

b. State your total annual earned income (including salary, bonus, and benefits) for the three (3) years prior to the date you first suffered the injury or illness through the present.

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

3. Have you directly paid or are you otherwise financially responsible for any medical expenses that are related to any injury(ies)/condition(s) you claim was/were caused by your use of PPIs and for which you seek recovery in the action you have filed?

Yes _____ No _____

If yes, state the approximate total amount of such expenses:

$_____

4. Has any insurer or any other entity or person paid any medical expenses related to any injury(ies)/condition(s) that you claim was/were caused by your use of PPIs and for which you seek recovery in the action you have filed?

Yes _____ No _____ Unsure_____

5. Other than your healthcare providers, please identify all persons whom you believe possess information concerning your alleged injury(ies) and/or other facts related to your claims:

Name	Address	Relationship to You

V. MEDICAL/HEALTH BACKGROUND

A. Height: _____

B. Current Weight: _____

C. Current family and/or primary care physician/healthcare provider:

_____

Name

_____

Street Address

_____

City, State, Zip Code

D. Identify each physician or other healthcare provider who diagnosed you with the kidney-related injury(ies), illness(es) and/or condition(s) you described in your response to the questions set forth in Section IV.A.2, above:

Name	Specialty	Address	Reason for Treatment

E. Identify each physician or other healthcare provider who treated you or with whom you consulted in connection with the kidney-related injury(ies), illness(es) and/or condition(s) you described in your response to the questions set forth in Section IV.A.2 above:

Name	Specialty	Address

F. To the best of your ability, other than the physicians and other healthcare providers you identified in response to questions V.D. and E. above, identify each physician or other healthcare provider from whom you have received treatment, including surgical procedures, during the last ten (10) years, or from two (2) years prior to the date you first used any PPI product, whichever is longer:

Name	Last Known Address	Approx. Dates of Treatment

G. Identify each hospital, clinic, surgical center, imaging center, physical therapy or rehabilitation center, or other healthcare facility where you have received inpatient or outpatient treatment for any condition, including emergency room treatment and/or surgical procedures, and imaging procedures (Ex. X-ray, CT (CAT) Scan, MRI, ultrasound, angiogram, or venogram) during the last ten (10) years, or from two (2) years prior to the date you first used any PPI product, whichever is longer:

Name	Address	Approx. Date of Admission	Reason for Admission

H. To the best of your recollection, identify on the chart below each prescription medication you have taken during the last ten (10) years, or from two years prior to the date you first used any PPI product, whichever is longer. In particular, in completing the chart below, please refer to the **table attached as Exhibit A** to this fact sheet to assist your recollection whether, within this time frame, you have taken any of the drugs identified in that table.

Prescription Medication	Reason Prescribed	Approximate Dates Taken	Full Name & Address of the Prescriber	Name and Address of Dispensing Pharmacy

I. Identify on the chart below any other (i.e., non-prescription) medications, including nonsteroidal anti-inflammatory drugs (ex. Ibuprofen), acetaminophen, aspirin, antihistamines (ex. Benadryl, Unisom), vitamins, herbal remedies and supplements, you have taken during the past five (5) years, or from two (2) years prior to the date you first used any PPI product, whichever is longer:

Medication	Reason Taken	Approximate Dates Taken

J. To the best of your recollection, identify from the list below all H2RAs (histamine receptor antagonists; also known as H2 blockers) (for example, Pepcid, Zantac) that you have taken in the last ten (10) years, or from the date you first used any PPI product, whichever is longer (check all that apply):

Medication	✓
Axid	
Axid AR (OTC)	
Cimetidine (prescription)	
Cimetidine (OTC)	
Cimetidine Hydrochloride (prescription)	
Duexis (prescription)	
Famotidine (prescription)	
Famotidine (OTC)	
Famotidine, Calcium Carbonate & Magnesium Hydroxide (OTC)	
Fluxid	
Nizatidine (Rx)	
Pepcid (prescription)	
Pepcid AC (OTC)	
Pepcid Complete (OTC)	
Tagamet HB (OTC)	
Zantac 150 (prescription)	
Zantac 150 (OTC)	
Zantac 300 (prescription)	
Zantac 75 (OTC)	
generic cimetidine	
generic famotidine	
generic nizatidine	
generic ranitidine	

K. For each of the products you identified in your response to V.K., above, state the following:

H2RA Product	Approximate Date(s) of Use	Name & Address of Prescriber (if applicable)	Name & Address of Dispensing Pharmacy

L. In the in the two (2) years *before* you first used any of the PPIs identified in your response to question III.A., above, did you take antacids such as Tums, Alka-Seltzer, Milk of Magnesia, Gaviscon, Pepto-Bismol, Rolaids, Maalox and/or Mylanta on a repeated or regular basis (i.e., two or more times a week)?

Yes _____ No _____

If yes, for each antacid product, state:

Antacid Product	Approximate Date(s) of Use	Dosage Taken (Ex. 20 mg, twice daily)	Name & Address of Healthcare Provider (if instructed by a healthcare provider to take the antacid)

M. To the best of your recollection, did you take antacids such as Tums, Alka-Seltzer, Milk of Magnesia, Gaviscon, Pepto-Bismol, Rolaids, Maalox and/or Mylanta on a repeated or regular basis (i.e., two or more times a week) *during the time* you were taking one or more of the PPIs identified in your response to question III.A., above?

Yes _____ No _____

If yes, for each antacid product, state:

Antacid Product	Approximate Date(s) of Use	Approx. amount taken	Name & Address of Healthcare Provider (if instructed by a healthcare provider to take the antacid)

N. <u>Kidney Specific Procedures</u>

Have you ever had a kidney procedure (as an in-patient or out-patient) performed, including, but not limited to, a kidney biopsy, dialysis, and/or lithotripsy?

Yes ____ No ____ Unsure ____

If yes, unless already identified above, for each procedure, list the date of the procedure, the reason for the procedure, any findings and the name of the treating physician or other healthcare provider.

_____
_____
_____

O. Tobacco Use

1. Please check and provide information for all that apply:

   a. Never smoked cigarettes _____

   b. Past smoker of cigarettes
   Date on which smoking ceased _____
   Amount smoked on average: _____ packs per day for _____ years

   c. Current smoker of cigarettes _____
   Amount smoked: _____ packs per day for _____ years

2. Have you ever used any other form of tobacco?

   Yes _____ No _____

   If yes, please identify:

   a. What form: _____

   b. Approx. dates of use: _____

   c. Amount of use on average: _____

P. Alcohol Use

1. Do you currently drink alcohol (beer, wine, liquor)?

   Yes ____ No ____

2. During the previous fifteen (15) years, have you consumed alcohol (beer, wine, liquor)?

   Yes _____ No ____

If yes, check the category below that represents your greatest alcohol consumption over an extended (3 months or greater) period within the last fifteen (15) years:

a. Approximately _____ drinks per day; or

b. Approximately _____ drinks per week; or

c. Approximately _____ drinks per month; or

d. Approximately _____ drinks per year; or

e. Other (describe): _____

Q. To the best of your knowledge and/or recollection, in the past ten (10) years, have you experienced, or been told by a physician or other healthcare provider, that you presently have, may have, or had any of the following at any time in your life (check all that apply)?

	Yes	No	Unsure
Anaphylaxis			
Angina			
Atherosclerosis			
Atrial fibrillation			
Benign prostatic hyperplasia (BPH)			
Bladder tumor			
Bladder stones			
Blood infection (bacteremia or sepsis)			
Bone infection (osteomyelitis)			
Cancer			
Cerebrovascular accident (Stroke)			
Cervical cancer			
Chronic kidney disease			
Circulatory disease			
Claudication			
Cirrhosis			
Colon cancer			
Congestive heart failure			
Congenital kidney disease			
Constipation			
	Yes	No	Unsure
Coronary Artery Disease			
Dehydration (severe)			
Diabetes			
Dyslipidemia / Hyperlipidemia			
Fanconi syndrome			
Fungal nephritis			
Glomerulonephritis			
Goodpasture syndrome			
Gout			
Granulomatosis with polyangiitis			
Heart failure			
Heart infection (endocarditis)			
Heavy metal exposure			
Hemolytic uremic			

syndrome			
Hepatitis B			
Hepatitis C			
Histoplasmosis			
HIV			
Hypercalcemia (elevated calcium levels)			
Hypertension (high blood pressure)			
Hypocalcemia			
Hypokalemia (low potassium levels)			
Hypomagnesemia			
Kawasaki disease			
Kidney cancer			
Kidney infection			
Kidney stones			
Lead poisoning			
Liver disease			
Liver failure			
Lupus nephritis			
Malaria			
Metabolic disturbances			
Multiple myeloma			
Mycobacterium			
Myocardial infarction			
Nephrocalcinosis			
Nephrotic syndrome			
Obesity			
Obstructive jaundice			
Peripheral vascular disease			
Polycystic kidney disease			
Pyelonephritis			
Renal arterial stenosis			
Renal tuberculosis			

Rhabdomyolysis			
Sarcoidosis			
Scleroderma			
Sepsis			
Shock (hypotension)			
Sickle cell disease			
Sjögren syndrome			
Skin infection			
Staph infection (*Staphylococcus*)			
Systemic inflammatory response syndrome			
Systemic lupus erythematosus (SLE)			
Throat infection (pharyngitis)			
Thrombotic microangiopathy			
Thrombotic thrombocytopenic purpura			
Tubulointerstitial nephritis with uveitis (TINU) syndrome			
Toxoplasmosis			
Urethral stricture			
Urinary Tract Infection			
Vasculitis			
Vesicoureteral reflux			
Wegener's granulomatosis			

Any infection caused by *Helicobacter pylori (H. pylori)*, *Streptococcus* (Step A, Strep B), *Enterococcus*, *E. coli*, adenovirus, *Mycobacterium*, Legionella, Epstein-Barr virus (EBV), cytomegalovirus (CMV)			

VI. FAMILY MEDICAL INFORMATION

A. Has any child, parent, sibling, or grandparent of yours related to you by blood ever been diagnosed with any of the injuries or conditions identified in your answer to question IV.A.2., above, including, but not limited to, acute kidney injury, acute interstitial nephritis, chronic kidney disease, kidney failure, end-stage renal disease, renal transplant, and dialysis treatment, etc.?

Yes _____ No _____ Unsure _____

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

1. Relationship to you: _____

   Injury or Condition: _____

2. Relationship to you: _____

   Injury or Condition: _____

3. Relationship to you: _____

   Injury or Condition: _____

VII. DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

_____ _____

Dated Signature

VIII. DOCUMENTS AND THINGS

A. Attach the following documents and things to this declaration in the manner set forth in the implementing order governing the Plaintiff Fact Sheet (CMO No. 9 (Plaintiff Fact Sheet and PFS Document Production)):

1. If you are alleging **prescription** PPI use, for each prescription PPI product by a named Defendant you claim caused your injuries, a medical, pharmacy, insurance, or other record substantiating your use of the PPI product.

2. If you are alleging **OTC** PPI use, for each OTC PPI you claim caused your injuries, a medical record or other record, a receipt or receipts, packaging, or other proof of purchase confirming the PPI, and that you purchased that PPI.

3. If you used only **samples** of a particular PPI before the date of the injury(ies) you identified in Section IV.A.2. above, either (1) an affidavit from a healthcare provider attesting that he or she provided you with a sample of the PPI you are claiming caused your alleged injury(ies), or (2) medical record(s) from a healthcare provider establishing that a sample of the specific PPI you identified was provided to you.

B. If you are completing this PFS on behalf of a deceased person, please attach a copy of the decedent's death certificate.

C. In addition to those documents you attached to this PFS in response to Requests A.1-3 above, please produce with this PFS a copy of all documents in your possession, custody or control responsive to the following document requests. This includes documents in the possession, custody or control of your agents, representatives, and attorneys within the meaning of Federal Rule of Civil Procedure 34(a)(1), with the exception of any documents protected by the attorney-client privilege or the work product doctrine. Please indicate whether you have any of the following materials by placing a checkmark next to the word "Yes" or "No" for each separate request.

1. All pharmacy records for each prescription name brand PPI (for example, Nexium®, Prilosec®, Prevacid®, etc.) and/or generic prescription PPI that you identified in response to question III.A., above, including receipts, prescriptions, and records of purchase.

   Yes ____ No ____

2. All insurance records substantiating that you filled a prescription for or otherwise obtained each of the prescription name brand, prescription

generic, and/or over-the-counter PPI products that you identified in response to question III.A., above.

Yes ____ No ____

3. For each and every OTC PPI product you identified in response to question III.A., above, all documents related to the product, including but not limited to, medical records, receipts, packaging, and patient guides.

Yes ____ No ____

4. All medical records referring to or relating to your use of any of the PPI products you identified in response to question III.A., above, including but not limited to, records of physicians or other healthcare providers, hospitals, surgery centers, and rehabilitation centers.

Yes ____ No ____

5. All documents referring or relating to your alleged injuries and any claimed damages, including but not limited to, medical bills, medical records, hospital records, rehabilitation center records, treatment center records, employments records, correspondence, e-mails, text messages, posts on social media sites, notes, calendar entries, and journals.

Yes ____ No ____

6. All packaging, including the box, bottle, or label, for PPIs you have taken, including any remaining medication (plaintiffs or their counsel must retain originals of the items requested).

Yes ____ No ____

7. All product-use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of PPIs.

Yes ____ No ____

8. All documents or other materials you have received from any healthcare provider relating to any PPI product or PPIs generally, including but not limited to, brochures, consent forms, and articles.

Yes ____ No ____

9. A copy of all other documents or materials that mention PPIs or any alleged health risks or hazards related to PPIs in your possession at or before the time of the injury alleged in your complaint, other than legal documents, documents provided by your attorney(s), or documents obtained or created for the purpose of seeking legal advice or assistance.

Yes ____ No ____

10. All documents you have generated, other than communications with your attorney(s), relating to any PPI or to any of the injuries you are claiming are related to your use of a PPI product, including letters and e-mail or other electronic messages you have written to healthcare providers or governmental entities.

Yes ____ No ____

11. All insurance-related documents that are applicable to the kidney-related injury(ies) or condition(s) that form the basis of your claim, including any application to any insurer for coverage, whether insurance was obtained or not.

Yes ____ No ____

12. Statements obtained from or given by any person, other than your attorney(s) or retained expert(s), having knowledge of the facts relevant to the subject of this litigation.

Yes ____ No ____

13. If you claim you have suffered a loss of earnings or earnings capacity, your W-2s and all tax records reflecting your income for the last three (3) years preceding the injury(ies) at issue in this litigation and every year thereafter for which you are claiming a loss of earnings or earnings capacity.

Yes ____ No ____

14. Copies of letters testamentary, letters of administration, powers of attorney, guardianship or guardian *ad litem* orders or other documents relating to your status as plaintiff if you are suing on behalf of another individual.

Yes ____ No ____

Exhibit A

Generic Name	Trade Name(s)
Analgesics	
Celecoxib	Celebrex
Diclofenac	Cambia, Cataflam, Voltaren,
Fenoprofen	Nalfon
Indomethacin	Indocid, Indocin
Ketorolac	Toradol
Meloxicam	Mobic, Metacam
Naproxen Rx	Anaprox, , Naprosyn
Oxaprozin	Daypro, Dayrun, Duraprox
Oxymorphone	Numorphan, Opana ER
Piroxicam	Feldene
Rofecoxib	Vioxx
Tramadol	Ultram
Antibiotics/Antivirals	
Abacavir	Ziagen
Acyclovir	Zovirax
Adefovir	Hepsera
Amikacin	Amikin
Amoxicillin	Moxatag
Amphotericin B	Fungizone, Mysteclin-F
Ampicillin	Principen
Atazanavir	Reyataz, Evotaz
Azithromycin	Zithromax, Azithrocin, Z-Pak
Cefaclor	Biocef, Ceclor, Distaclor, Keflor, Raniclor
Cefadroxil	Duricef
Cefalexin	Keflex, Cepol, Ceporex
Cefazolin	Ancef, Cefacidal, Kefzol
Cefixime	Suprax
Cefotetan	Cefotan
Cefuroxime	Ceftin, Zinacef
Cefprozil	Cefzil
Ceftriaxone	Rocephin, Epicephin
Chloramphenicol	Pentamycetin, Chloromycetin
Cidofovir	Vistide
Ciprofloxacin	Ciloxan, Cipro, Neofloxin
Cyclosporin	Neoral, Sandimmune
Doxycycline	Doryx, Doxyhexal, Doxylin, Vibramycin
Erythromycin	Eryc, Erythrocin
Foscarnet	Foscavir
Gentamicin	Cidomycin, Septopal, Genticyn, Garamycin
Indinavir	Crixivan
Itraconazole	Sporanox, Orungal, Onmel
Kanamycin	

Generic Name	Trade Name(s)
Levofloxacin	Levaquin
Methicillin	
Minocycline	Minocin, Minomycin, Akamin
Moxifloxacin	Avelox, Vigamox, Moxeza
Neomycin	Neo-rx
Netilmicin	
Penicillin	
Pentamidine	Nebupent, Pentam
Polymyxin E	Colistin
Quinine	Qualaquin
Rifampicin	Rifadin
Streptomycin	
Sulfadiazine	
Tenofovir	Viread
Tetracycline	Sumycin
Tobramycin	Tobrex
Trimethoprim	Proloprim, Monotrim, Triprim, Primsol
Trimethoprim/ Sulfamethoxazole (TMP/SMX)	Bactrim, Bactrim DS, Cotrim, Septra, Sulfatrim
Vancomycin	Vancocin
Cardiovascular	
ACE inhibitors	
Benazepril	Lotensin
Captopril	Capoten
Enalapril	Vasotec, Renitec, Enap
Lisinopril	Prinivil, Zestril
Quinapril	Accupril
Ramipril	Altace
Angiotensin II Receptor Antagonist (ARB)	
Azilsartan	Edarbi
Irbesartan	Avapro
Losartan	Cozaar
Olmesartan	Olmecip, Benicar
Telmisartan	Micardis
Valsartan	Diovan
Other Anti-hypertensives/Diuretics	
Bumetanide	Bumex
Chlortalidone	Hygroton
Furosemide	Lasix
Hydrochlorothiazide (HCTZ)	Apo-hydro
Mannitol	
Spironolactone	Aldactone, Spiractin, Verospiron
Spironolactone/ HCTZ	Aldactazide
Torsemide	Demadex, Tortas

Generic Name	Trade Name(s)
Triamterene	Dyrenium, Dyazide, Maxzide
Statins	
Atorvostatin	Lipitor, Ator
Cerivastatin	Lipobay, Baycol
Fluvastatin	Lescol, Lescol XL
Lovastatin	Mevacor, Altocor, Altoprev
Mevastatin	Compactin
Pitavastatin	Livalo, Livazo, Pitava
Pravastatin	Pravachol, Selektine, Lipostat
Rosuvastatin	Crestor
Simvastatin	Zocor, Lipex
Other	
Dopamine	
Hydralazine	
Norepinephrine	
Gastrointestinal	
Mesalazine, Mesalamine	Asacol, Azacol, Lialda, Pentasa, Apriso, Rowasa
Sulfasalazine	Azulfidine, Salazopyrin, Sulazine
Immunosuppressant	
Allopurinol	Zyloprim
Cyclosporine	Neoral
Tacrolimus	Prograf, Advagraf, Protopic
Hematology/Anticoagulants	
Clopidogrel	Plavix
Ticlopidine	Ticlid
Neurologic	
Amitriptyline	Amitrip, Elavil, Levate
Carbamazepine	Tegretol
Doxepin	Sinequan
Fluoxetine	Prozac, Sarafem, Adofen
Haloperidol	Haldol
Lithium	
Phenobarbital	
Phenytoin	Dilantin
Valproate	Convulex, Depakote, Epilim, Stavzor
Chemotherapy	
Aflibercept	Eylea, Zaltrap
Axitinib	Inlyta
Bevacizumab	Avastin
Carboplatin	

Generic Name	Trade Name(s)
Carmustine	Gliadel
Cisplatin	Platinol
Cyclophosphamide	Cytoxan, Neosar
Gemcitabine	Gemzar
Ifoxfamide	Ifex
Interferon, Interferon-alfa	Roferon A, Intron A, Multiferon, Actimmune, Pegasys, PegIntron
Methotrexate	Trexall, Rheumatrex
Mitomycin-C	Mutamycin
Pazopanib	Votrient
Sunitinib	Sutent
Nitrosoureas	
Lomustine	
Semustine	
Rheumatology	
Penicillamine	
Other	
Acetazolamide	Diamox, Diacarb
Contrast Media -- Any contrast medium or agent for medical imaging	

EXHIBIT B

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(Excluding Psychiatric, Psychological, and Mental Health Treatment Notes/Records)
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Patient Date of Birth Social Security Number

This will authorize you to furnish copies of the following records and/or information **from the time period of twelve (12) years prior to the date on which the authorization is signed**:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
* All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and catheterization reports.
* All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.

****Notwithstanding the broad scope of the above disclosure requests, the undersigned does not authorize the disclosure of notes or records pertaining to psychiatric, psychological, or mental health treatment or diagnosis as such terms are defined by HIPAA, 45 CFR §164.501**.

1. To my medical provider: **This authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial**.
2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.
5. A notarized signature is not required. A copy of this authorization may be used in place of an original.
6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040**.**

Date:_____ _____
Patient/Representative Signature *[Print name if not Patient]*

Date:_____ _____
Witness Signature

EXHIBIT C

LIMITED AUTHORIZATION TO DISCLOSE PSYCHIATRIC,
PSYCHOLOGICAL AND/OR MENTAL HEALTH TREATMENT NOTES/RECORDS
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Patient Date of Birth Social Security Number

This will authorize you to furnish copies of the following records and/or information **from the time period of twelve (12) years prior to the date on which the authorization is signed**:

- 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 conversations 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.

1. To my medical provider: **This authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial**.
2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.
5. A notarized signature is not required. A copy of this authorization may be used in place of an original.
6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040**.**

Date:_____ _____
Patient/Representative Signature *[Print name if not Patient]*

Date:_____ _____
Witness Signature

EXHIBIT D

LIMITED AUTHORIZATION TO DISCLOSE
EMPLOYMENT RECORDS AND INFORMATION
(HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508)

To: _____
Name of Employer

_____
Address

_____
City, State and Zip Code

I authorize the limited disclosure of my employment records for the purpose of review and evaluation in connection with a legal claim, including medical information protected by HIPAA, 45 CFR 164.508; copies of all applications for employment; resumes; records of all positions held; job descriptions of positions held; wage and income statements and/or compensation records; wage increases and decreases; evaluations, reviews and job performance summaries; W-2s; employee health files, and correspondence and memoranda regarding the undersigned. **This authorization only authorizes release of Health Insurance records and/or information from the time period of ten (10) years prior to the date on which this authorization is signed**.

_____ _____ _____
Name of Employee Date of Birth Social Security Number

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040.

This authorization does not authorize you to disclose anything other than documents and records to anyone. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

I acknowledge the right to revoke this authorization by writing to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

Date: _____ _____
Employee/Guardian/Personal Representative
Signature *[Print name if not Employee]*

Date: _____ _____
Witness Signature

LARGER FONT VERSIONS OF THIS AUTHORIZATION AVAILABLE ON REQUEST

EXHIBIT E

LIMITED AUTHORIZATION FOR RELEASE OF HEALTH INSURANCE RECORDS
(HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508)

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all insurance claims applications and benefits, and all medical, health, hospital, physicians, nursing or allied health professional reports, records or notes, invoices and bills, in your possession that pertain to the named insured identified below. **This authorization only authorizes release of Health Insurance records and/or information from the time period of twelve (12) years prior to the date on which this authorization is signed**.

_____ _____ _____
Name of Insured Date of Birth Social Security Number

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040**.**

This authorization only authorizes release of documents and records from the period of twelve (12) years prior to the date on which this authorization is signed. This authorization does not authorize you to disclose anything other than documents and records to anyone.

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

Date:_____ _____
Insured/Guardian/Personal Representative
Signature *[Print name if not Insured]*

Date:_____ _____
Witness Signature

LARGER FONT VERSIONS OF THIS AUTHORIZATION AVAILABLE ON REQUEST

EXHIBIT F

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.** 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".

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

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

- **Option 1** To **include** all information, check the box: "all information, including information about alcohol and drug abuse, mental health treatment, and HIV". Proceed with the rest of the form.

- **Option 2** To **exclude** the information listed above, check the box: "Exclude information about alcohol and drug abuse, mental health treatment and HIV". Then proceed with the rest of the form.

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

Sincerely,

1-800-MEDICARE
Customer Service Representative

Encl.

Form Approved
OMB No. 0938-0930

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, 000000000A).

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. Box 2C must be completed by **New York Residents**.

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.

Form Approved
OMB No. 0938-0930

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.

Form Approved
OMB No. 0938-0930

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 <u>one</u> box below to tell Medicare the specific personal health information you want disclosed:

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

2B: Complete <u>only</u> if you selected "limited information". Check all that apply:

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

_____

_____

2C: NY Residents Only, this section must be completed.
Please select one of the following options: (Please check only one box.)

- ☐ Include all information. This includes information about alcohol and drug abuse, mental health treatment, and HIV.

OR

- ☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV.

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

☐ Disclose my personal health information indefinitely

☐ Disclose my personal health information for a specified period only

beginning: _____ (mm/dd/yyyy) and ending: _____ (mm/dd/yyyy)

4. **Fill in the name and address of the person or organization to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person for any organization you list below. If you would like to authorize any additional individuals or organizations, please add those to the back of this form.**

Name _____

Address _____

Name _____

Address _____

Form Approved
OMB No. 0938-0930

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. To revoke authorization, send a written request to the address noted below. 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.

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

_____ _____ _____

Signature | Telephone Number | Date (mm/dd/yyyy)

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

_____

_____

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

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

_____

_____

Telephone Number of Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

Form Approved
OMB No. 0938-0930

6. **Send the completed, signed authorization to**:

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

PrintForm

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 authorization, send a written request to the address noted 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 G

LIMITED AUTHORIZATION FOR RELEASE
OF WORKERS' COMPENSATION RECORDS
(HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508)

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all workers' compensation records of any sort **for any workers' compensation claims filed within the last twelve (12) years**, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____	_____	_____
Name of Claimant	Date of Birth	Social Security Number

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040**.**

This authorization only authorizes release of documents and records from the period of twelve (12) years prior to the date on which this authorization is signed. This authorization does not authorize you to disclose anything other than documents and records to anyone.

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

Date:_____ _____
Claimant/Guardian/Personal Representative
Signature *[Print name if not Claimant]*

Date:_____ _____
Witness Signature

LARGER FONT VERSIONS OF THIS AUTHORIZATION AVAILABLE ON REQUEST

EXHIBIT H

LIMITED AUTHORIZATION FOR RELEASE OF
DISABILITY CLAIMS RECORDS
(HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508)

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all records of disability claims of any sort **for any disability claim(s) filed within the last twelve (12) years**, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____ _____ _____
Name of Claimant Date of Birth Social Security Number

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040.

This authorization only authorizes release of documents and records from the period of twelve (12) years prior to the date on which this authorization is signed. This authorization does not authorize you to disclose anything other than documents and records to anyone.

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

Date: _____ _____
Claimant/Guardian/Personal Representative
Signature *[Print name if not Claimant]*

Date: _____ _____
Witness Signature

LARGER FONT VERSIONS OF THIS AUTHORIZATION AVAILABLE ON REQUEST

EXHIBIT I

LIMITED AUTHORIZATION FOR RELEASE OF RECORDS
(HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508)

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all records of purchase history, receipts, rebates/coupons, or any other record of any sort referring to the purchase of any of the following over-the-counter Proton Pump Inhibitor ("PPI") products, **and only such products**, including but not limited to:

*Lansoprazole OTC
*Nexium 24HR
*Omeprazole OTC
*Omeprazole Magnesium OTC
*Omeprazole/Sodium Bicarbonate OTC
*Prevacid 24HR
*Prilosec OTC
*Zegerid OTC
*Any private label or store brand versions of any PPI

_____ _____ _____
Name of Claimant Date of Birth Social Security Number

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040.

This authorization only authorizes release of documents and records from the period of twelve (12) years prior to the date on which this authorization is signed. This authorization does not authorize you to disclose anything other than documents and records to anyone.

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

Date: _____ _____
Claimant/Guardian/Personal Representative Signature *[Print name if not Claimant]*

Date: _____ _____
Witness Signature

LARGER FONT VERSIONS OF THIS AUTHORIZATION AVAILABLE ON REQUEST

EXHIBIT J

Instructions for Uploading Plaintiff Fact Sheet and Documents

Pursuant to Section V.C. of the Case Management Order governing the Plaintiff Fact Sheet ("PFS") and PFS Document Production, each Plaintiff shall serve his or her PFS and documents responsive to the requests for production of documents set forth therein upon Defendants by uploading them to the ShareFile site maintained by The Marker Group at https://tmg-data.com/ as follows:

1. Log in to https://tmg-data.com/.

2. When prompted, enter the user ID and password for your firm that was provided to you by Marker Group.

3. Click Login.

4. Upon your first login, you will be prompted to download Java.

5. Once your download is complete, you will be re-directed to your homepage automatically.

6. Select file(s) located from your computer on the left hand side of the screen.

7. Once you selections are complete, click the Upload button with the green up arrow.

8. A progression of the transfer will appear in the bottom window.

9. Once all files have been uploaded, they will appear on the right side of the window.