UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW HAMPSHIRE

In Re: Atrium Medical Corp. C-Qur Mesh
Products Liability Litigation (MDL No. 2753)

MDL Docket No. 16-md-2753-LM
ALL CASES

FOURTH AMENDED CASE MANAGEMENT ORDER NO._3G[1]
ENABLING ORDER FOR PPF, PFS, DPF, DFS,
AND JOINT RECORDS COLLECTION

1. Plaintiff Profile Form

a. For all cases Plaintiffs and Defendants ("the parties") have agreed upon the use of an abbreviated Plaintiff Profile Form ("PPF"), attached hereto as Exhibit A. The PPF shall be completed in each case.

b. For each Plaintiff in a case on file as of the date of the entry of this Order, a completed PPF will be submitted to Defendants within sixty (60) days of the entry of this Order. Each Plaintiff in a case filed or transferred into this MDL after the date of the entry of this Order shall submit a completed PPF within sixty (60) days of filing the Short Form Complaint or of the entry of the finalized transfer order.

c. A completed PPF shall not be considered interrogatory answers under Fed. R. Civ. P. 33 or responses to requests for production under Fed. R. Civ. P. 34, however completeness and compliance will be governed by the standards applicable to written discovery under Federal Rules 26 through 37.

[1]Exhibit F has been amended per the court's endorsed order dated 10/16/19.

d. Contemporaneous with the submission of a PPF, each Plaintiff shall provide Defendants hard copies or electronic files of all medical records in their possession, custody, or control that pertain to Plaintiff's hernia mesh implant and post-implant care and treatment, including in particular records that support product identification.

e. Contemporaneous with the submission of a PPF, each Plaintiff shall also produce signed authorizations applicable to that Plaintiff's claims in each case, attached hereto as Exhibit B. Such documents include authorizations for the release of medical, insurance, employment, Medicare/Medicaid, military, income verification and Social Security records from any healthcare provider, hospital, clinic, outpatient treatment center, and/or any other entity, institution, agency or other custodian of records identified in the PPF. In the event an institution, agency or medical provider to whom a signed authorization is presented refuses to provide responsive records, the individual Plaintiff's attorney shall expeditiously 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, psychologist, clinical social worker, or other provider, shall first be available to counsel for the Plaintiff who shall have ten (10) days to review the documents for an objection, withhold any such records, notify counsel for the requesting defendant and provide an log asserting the basis for the withholding of documents. Absent notification within ten (10) days of the assertion of withholding and the provision of a log, the records shall then be provided to the requesting defendant.

f. Every Plaintiff that is required to provide Defendants with a PPF must provide one that is substantially complete in all respects, answering every question in the PPF, even if a

Plaintiff can answer the question in good faith only by indicating "not applicable." The PPF shall be signed by Plaintiff under penalty of perjury.

g. If a Plaintiff fails to timely submit a PPF or if Defendants receive a PPF, as applicable, in the allotted time but the PPF is not substantially complete, Defendants' Counsel shall send a deficiency letter consistent with the deficiency process set forth below for Plaintiff Fact Sheets ("PFS"). Plaintiffs shall then be allowed seven (7) days to cure the deficiency. Otherwise, the parties will follow the deficiency process outlined for Plaintiff Fact Sheets below.

2. Plaintiff Fact Sheet (PFS)

a. Plaintiffs selected into the initial bellwether group, as to be later determined by the Court or agreement of counsel, shall submit a full PFS, in the form agreed upon by the parties and attached hereto as Exhibit C. A fully signed and completed PFS shall be due within ninety (90) days from the date the Court enters an Order placing a plaintiff's case into an initial bellwether group. Each PFS shall be served with a complete copy of the already collected medical records. With respect to Plaintiffs who are not selected for inclusion in the initial bellwether group, the PFS shall be due within forty-five (45) days of the date the Court enters an order placing a Plaintiff's case within a subsequent bellwether group or otherwise placing the case into a pool requiring case-specific discovery or remanding the case to the transferor court.

b. Every Plaintiff completing a PFS is required to provide Defendants with a PFS that is substantially complete in all aspects and completed copies of the releases described above. A completed PFS 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 Fed. R. Civ. P. 26 through 37.

c. If a Plaintiff fails to timely submit a PFS or if Defendants receive a PFS in the allotted time but the PFS is not substantially complete, Defendants' Counsel shall send a deficiency letter by email and U.S. Mail to Plaintiffs' Liaison Counsel and the individual Plaintiff's attorney specifically identifying the purported deficiencies by PFS question number. Plaintiff shall have twenty (20) days from receipt of the letter to respond or otherwise serve a PFS that is substantially complete in all respects. Should a Plaintiff fail to cure the deficiencies identified, Defendant may, after conducting the prerequisite meet and confer, move under Fed. R. Civ. P. 37 for appropriate relief.

3. Defendant's Profile Form ("DPF")

a. A fully signed and completed Defendant's Profile Form, attached hereto as Exhibit D, shall be served within sixty (60) days from the receipt of a signed PPF.

b. Each Defendant is required to provide each Plaintiff with a DPF that is substantially complete in all aspects. A completed DPF shall not be considered interrogatory answers under Fed. R. Civ. P. 33 or responses to requests for production under Fed. R. Civ. P. 34, but will be governed by the standards applicable to written discovery under Fed. R. Civ. P. 26 through 37.

c. If a Defendant fails to timely submit a DPF or if a Plaintiff receives a DPF in the allotted time but the DPF is not substantially complete, Plaintiffs' Lead or Liaison Counsel or the individual Plaintiff's attorney shall send a deficiency letter by email and U.S. Mail to Defendant's Liaison Counsel identifying the purported deficiencies. Defendant shall have twenty (20) days from receipt of the letter to serve a DPF 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, Plaintiff may, after conducting the prerequisite meet and confer, move under Fed. R. Civ. P. 37 for appropriate relief.

4. Defendant Fact Sheet ("DFS")

a. A fully signed and completed Defendant's Fact Sheet, attached hereto as Exhibit E, shall be served within ninety (90) days from the receipt of a signed PFS.

b. Each Defendant is required to provide each Plaintiff with a DFS that is substantially complete in all aspects. 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 Fed. R. Civ. P. 26 through 37.

c. If a Defendant fails to timely submit a DFS or if a Plaintiff receives a DFS in the allotted time but the DFS is not substantially complete, Plaintiffs' Lead or Liaison Counsel or the individual Plaintiff's attorney shall send a deficiency letter by email and U.S. Mail to Defendant's Counsel identifying the purported deficiencies. Defendant shall have twenty (20) days from receipt of the 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, Plaintiff may, after conducting the prerequisite meet and confer, move under Fed. R. Civ. P. 37 for appropriate relief.

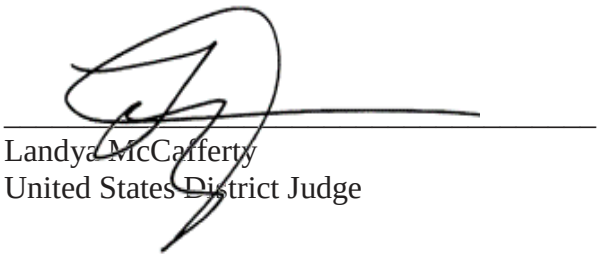
d. Items within the Defendant Fact Sheet have not been agreed to by the Defendants. Accordingly, the parties have agreed that the Defendants have not waived and in fact have

reserved their right to object to the questions in the Defendant Fact Sheet. Defendants may interpose objections, where appropriate, to any particular question or request for documents. However, Defendants have agreed not to assert any objection to the Defendant Fact Sheet on the grounds of numerosity. All objections must comply with the applicable Federal Rules of Civil Procedure.

5. Joint Records Collection

a. The parties have stipulated to, and the court hereby approves, a Joint Records Collection Agreement, attached hereto as Exhibit F.

SO ORDERED.



Landya McCafferty
United States District Judge

August 3, 2017

cc: All Counsel of Record

AMENDED*

EXHIBIT A

*Amended 1/12/18

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW HAMPSHIRE

IN RE:	)	**MDL NO. 2753**
ATRIUM MEDICAL CORP. C-QUR MESH PRODUCTS LIABILITY LITIGATION	)	**MDL Docket No. 1:16-md-02753-LM**
	)	**ALL CASES**

AMENDED PLAINTIFF PROFILE FORM

In completing this Amended Plaintiff Profile Form, you are under oath and must provide information that is true and correct to the best of your knowledge. The Amended Plaintiff Profile Form shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order ("CMO"). Service of the Amended Plaintiff Profile Form shall be via electronic mail to the individuals identified in CMO No. 2.

I. CASE INFORMATION

Caption:

Date:

Docket No.:

Plaintiff's attorney and Contact information: _____

_____

Court where case originally filed or would have been filed absent direct filing into this MDL: _____

II. PLAINTIFF INFORMATION

Name: _____

Maiden Name (if any): _____

Other names by which you have been known (from prior marriages or otherwise):

_____

Male: _____ **Female:** _____

Address: _____

Date of birth: _____

Social Security No.: _____

Spouse's Name:_____**Loss of Consortium? ☐Yes ☐ No**

Spouse's Maiden Name (if any): _____

Other names by which your spouse has been known (from prior marriages or otherwise):

_____

Spouses' Gender Male: _____**Female:** _____

Spouse's Address: _____

Spouse's Date of birth: _____

Spouse's Social Security No.: _____

[1]

III. DEVICE INFORMATION

Date of implant:

Reason for Implantation:

Brand Name: **Mfg.**

Lot Number:

Implanting Surgeon:

Medical Facility:

Date of implant:

Reason for Implantation:

Brand Name: **Mfg.**

Lot Number:

Implanting Surgeon:

Medical Facility:

• ***Attach medical evidence of product identification.***

IV. REMOVAL/REVISION SURGERY INFORMATION

[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 surgery(s) or anticipated surgery(s):

Type of surgery(s):

Explanting surgeon:

Medical Facility:

Reason for Explant:

Location of Explanted Device:

Date of surgery(s) or anticipated surgery(s):

Type of surgery(s):

Explanting surgeon:

Medical Facility:

Reason for Explant:

Location of Explanted Device:

V. OUTCOME ATTRIBUTED TO DEVICE

☐ **Pain**	☐ **Failed graft incorporation**
☐ **Adhesion**	☐ **Recurrence**
☐ **Extrusion**	☐ **Bleeding**
☐ **Infection**	☐ **Seroma**
☐ **Fistulae**	☐ **Erosion**
☐ **Bowel blockage**	☐ **Emotional/psychological injuries with treatment**
☐ **Organ Perforation**	☐ **Emotional/psychological injuries without treatment**
☐ **Abscess**	☐ **Other**

Date of First Diagnosis or Occurrence of Above-Identified Outcome(s): _____

VI. PAST HISTORY

Number of Prior Abdominal Surgeries: _____

Number of Prior Hernia Surgeries: _____

Name of Hospital	Address of Hospital	Type of Surgery	Approx. Date of Surgery

Prior to the First Implant, Have You Ever Had or Been Diagnosed with:

_____ **Lupus**
_____ **Diabetes**
_____ **Auto Immune Disorder**
_____ **Adhesive Disease**
_____ **Disease of the Gallbladder**
_____ **Crohn's Disease**
_____ **Colitis**
_____ **Diverticulitis**
_____ **Hypertension**
_____ **Obesity**
_____ **History of Tobacco Use**

Type of Tobacco (cigarettes, cigars, chewing tobacco)	Frequency of Use (packs per day)	Start date	End date

Are you claiming damages for lost wages: [ ] Yes [ ] No

If so:

For what time period: _____

Identify your employer (and provide address) at the time you incurred lost wages:

_____

_____

Identify your title/occupation at the time you incurred lost wages: _____

_____

Name and Address of each pharmacy where you have had prescriptions filled for the last ten (10) years:

Name of Pharmacy	Address of Pharmacy	Approx. Dates of Use

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

Name of Insurance Company	Policy Number	Name of Policy Holder/Insured (if different than you)	Approx. Dates of Coverage

Have you applied for social security, or state or federal disability benefits within the past ten (10) years? Yes_____No_____

If Yes, then as to each application, separately state:

1. Was claim denied? Yes_____No_____

2. To what agency or company did you submit your application:

   _____

3. Claim/docket number, if applicable:_____

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 OF ALL TREATING PHYSICIANS FOR THE PERIOD OF 10 YEARS PRIOR TO THE FIRST MESH IMPLANT, INCLUDING ALL PRIMARY CARE PHYSICIANS, SURGEONS, GASTROENTEROLOGISTS, 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: _____

SURGEONS:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

GASTROENTEROLOGISTS:

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 AND DOCUMENT PRODUCTION

1. Provide ONE (1) SIGNED ORIGINAL copy of each of the records authorization forms attached as Ex. A. These authorization forms will authorize the records vendor selected by the parties to obtain those records identified in the authorizations from the providers identified within this Amended Plaintiff Profile Form.

2. Produce all documents in your possession, custody or control concerning any occasion on which you saw a doctor or other health care provider regarding any injury or physical or psychological complaint for which you claim compensation in this lawsuit, including but not limited to all medical reports and records; psychological assessments and records; and laboratory findings and reports.

i. The documents are attached_____[OR] I have no documents _____

3. Produce all medical and hospital bills or receipts, and documents in your possession, custody or control reflecting any and all payments made for same, including, but not limited to, any hospital and health care professional bills incurred because of the injuries you allege you have incurred as a result of your use of the C-QUR™ Mesh.

i. The documents are attached_____[OR] I have no documents _____

4. Produce any communications in your possession, custody or control (sent or received), excluding communications with your lawyers, concerning the C-QUR™ Mesh, including but not limited to e-mails, blogs, newsletters, etc.

i. The documents are attached_____[OR] I have no documents _____

5. Produce any notes, diaries, or other documents in your possession custody or control evidencing your physical or mental condition, including but not limited to the injuries for which you claim relief in this lawsuit.

i. The documents are attached_____[OR] I have no documents _____

6. Produce any C-QUR™ Mesh packaging, labeling, advertising, or any other C-QUR™ Mesh-related items in your possession, custody or control.

i. The documents are attached_____[OR] I have no documents _____

7. Produce all documents in your possession, custody or control evidencing or relating to any correspondence or communication between Atrium Medical Corporation and any of your doctors, healthcare providers, and/or you relating to the C-QUR™ Mesh .

i. The documents are attached_____[OR] I have no documents _____

8. Produce any and all documents in your possession, custody or control relating to the recall of the C-QUR™ Mesh that you received and/or reviewed at any time prior to filing this lawsuit.

i. The documents are attached_____[OR] I have no documents _____

9. 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 the C-QUR™ Mesh concerning the risks and/or benefits of your hernia repair surgery, including but not limited to any risks and/or benefits associated with the C-QUR™ Mesh.

i. The documents are attached_____[OR] I have no documents _____

10. Produce any and all documents in your possession, custody or control reflecting the size, model number, and lot number of the C-QUR™ Mesh you received.

i. The documents are attached_____[OR] I have no documents _____

11. If you underwent surgery to explant in whole or in part the C-QUR™ Mesh that you received, produce any and all documents in your possession, custody or control relating to any evaluation of the C-QUR™ Mesh and any other material that was(were) surgically removed from you.

i. The documents are attached_____[OR] I have no documents _____

12. Produce any documents, including print outs or screen shots, in your possession, custody or control that refer or relate to C-QUR™ Mesh or hernia repair.

i. The documents are attached_____[OR] I have no documents _____

13. Produce any photographs, digital images, video or similar media in your possession, custody or control that depicts your hernia that was repaired with C-QUR™ Mesh, the incision and or scarring resulting from the C-QUR™ Mesh or hernia repair procedure or revision, if any, and/or any physical condition that you contend was caused by C-QUR™ Mesh or your C-QUR™ Mesh hernia repair.

i. The documents are attached_____[OR] I have no documents _____

SWORN DECLARATION

Plaintiff,_____, deposes and states as follows:

I declare under penalty of perjury that all of the information provided in this Amended Plaintiff Profile Form is true and correct to the best of my knowledge, information and belief; I have supplied all the documents requested in this Amended Plaintiff Profile Form to the extent that such documents are in my possession, custody, or control; and I have supplied the records authorizations requested in and attached to this Amended Plaintiff Profile Form.

_____ _____

Date Signature of Plaintiff

SWORN DECLARATION

Consortium Plaintiff,_____, deposes and states as follows:

I declare under penalty of perjury that all of the information provided in this Amended Plaintiff Profile Form is true and correct to the best of my knowledge, information and belief; I have supplied all the documents requested in this Amended Plaintiff Profile Form to the extent that such documents are in my possession, custody, or control; and I have supplied the records authorizations requested in and attached to this Amended Plaintiff Profile Form.

_____ _____

Date Signature of Consortium Plaintiff

Amended*

EXHIBIT B

*Amended 5/13/19

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL AND HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO: _____

Patient Name: _____

DOB: _____

SSN: _____

I,_____, hereby authorize you to release and furnish to: Litigation Management Inc. ("LMI"), 6000 Parkland Blvd., Mayfield Hts., OH 44124) COPIES ONLY of the following information:

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

1. To my medical provider: this authorization is being forwarded by, or on behalf of, attorneys for the parties to civil litigation. This authorization is construed to permit agents or designees of LMI and/or the parties to copy, inspect and review any and all such records.

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to LMI at the above address. 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 upon resolution of the litigation, through and including any appellate disposition.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I have a right to a copy of same. 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 re-disclosure and the information may not be protected by federal confidentiality rules. If 1 have questions about disclosure of my health information, I can contact the releaser indicate above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name: _____(plaintiff/representative)

Signature: _____ _____

Date

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;

Social Security Administration; and

Department of the Treasury/Internal Revenue Service;

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 Litigation Management, Inc. ("LMI") 6000 Parkland Boulevard, Mayfield Heights, OH 44124 and its authorized representatives, with 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 concerning C-Qur™ hernia mesh.

- 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 either Litigation Management Inc. (6000 Parkland Boulevard, Mayfield Heights, OH 44124) 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 furnished to LMI, pursuant to this authorization will be shared with any and all of the attorneys for the parties in the C-Qur™ hernia mesh litigation 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 later of: (i) the date of settlement or final disposition of undersigned's Q-Qur™ hernia mesh litigation.

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to Litigation Management, Inc. 6000 Parkland Boulevard, Mayfield Heights, OH 44124, and its authorized representatives, by any entities included in the categories listed above.

Date:_____ _____

Signature of Individual or Individual's Representative

Printed Name of Individual's Representative (If applicable) _____

_____

Relationship of Representative to 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 FOR RELEASE OF EDUCATIONAL RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of all school records including, but not limited to, test results, test scores, report cards, or other school grading material, attendance records, physicals and other health-related, including but not limited to any physicians, nursing or allied health professional reports, records or notes, which may be in your possession.

_____
Name of Student

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

You are authorized to release the above records to Litigation Management Inc. (6000 Parkland Boulevard, Mayfield Heights, OH 44124 who have agreed to pay reasonable charges made by you to supply copies of such records.

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: _____ _____
Student/Name

HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508
EMPLOYMENT AUTHORIZATION

TO: _____
Name of Employer

_____
Address, City State and Zip Code

RE: Employee Name: _____ aka _____

Date of Birth: _____Social Security Number: _____

Address: _____

I authorize the disclosure of my employment records including any medical information protected by HIPAA, 45 CFR 164.508, for the purpose of review and evaluation in connection with a legal claim. I expressly request that all entities identified above disclose full and complete records including the following:

This will authorize you to furnish copies of all applications for employment; resumes; records of all positions held; job descriptions of positions held; wage and income statements and/or compensation records; wage increases and decreases; performance evaluations, reviews and reports; transfers, statements and comments of fellow employees; all documents relating to discipline including warnings, reprimands, suspensions, terminations, and all other forms of discipline; attendance records; W-2s, worker's compensation files; all medical records, x- rays and test results; any physical examination records; all documents relating to my absences, illnesses and injuries; any records pertaining to claims made relating to health, disability or accidents in which 1 was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf; and any other records relating to my employment and/or in my personnel file. Information about HIV/AIDS and alcohol/substance abuse may be disclosed.

I authorize you to release the information to; Litigation Management Inc. (6000 Parkland Boulevard, Mayfield Heights, OH 44124.

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requestor at that time.

I acknowledge the right to revoke this authorization by writing to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the

entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization expires upon the resolution of my litigation, through and including any appellate disposition, concerning C-Qur™ hernia mesh.

_____

Signature of Employee or Personal Representative

_____

Name of Employee or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority to Sign for Employee (attach documents that show authority)

AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS

To: _____
Name

_____
Address

_____
City, Slate and Zip Code

This will authorize you to furnish copies of all forms regarding insurance claims applications and benefits and all medical, health, hospital, physicians, nursing or allied health professional reports, records, notes or invoices and bills, which may be in your possession.

_____
Name of Insured

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

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records: Litigation Management Inc. (6000 Parkland Boulevard, Mayfield Heights, OH 44124.

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, if 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.

_____ _____
Name/Signature Date

Form **4506-T**
(July 2017)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

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b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

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9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

12 / 31 / 2018	12 / 31 / 2017	/ /	/ /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) — Date

▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** — Date

Form **4506-T**
(July 2017)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

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OMB No. 1545-1872

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12 / 31 / 2016	12 / 31 / 2015	12 / 31 / 2014	12 / 31 / 2013

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☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ _____ _____
Signature (see instructions) Date

▶ _____
Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ _____
Spouse's signature Date

Form **4506-T**
(July 2017)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

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OMB No. 1545-1872

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12 / 31 / 2012	12 / 31 / 2011	12 / 31 / 2010	12 / 31 / 2009

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Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) — Date

▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** — Date

Form **4506-T**
(July 2017)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

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OMB No. 1545-1872

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12 / 31 / 2008	12 / 31 / 2007	12 / 31 / 2006	/ /

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Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) | Date

▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** | Date

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

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

***NAME OF PERSON OR ORGANIZATION:**

LITIGATION MANAGEMENT INC.

***ADDRESS OF PERSON OR ORGANIZATION:**

6000 PARKLAND BOULEVARD

MAYFIELD HEIGHTS, OHIO 44124

***I want this information released because:** LITIGATION REQUEST

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☒ Current monthly Social Security benefit amount
3. ☒ Current monthly Supplemental Security Income payment amount
4. ☒ My benefit or payment amounts from date 2007 to date 2019
5. ☒ My Medicare entitlement from date 2007 to date 2019
6. ☒ Medical records from my claims folder(s) from date 2007 to date 2019

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☒ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

   CONSULTATIVE EXAMS, AWARD/DENIAL NOTICES, BENEFIT APPLICATIONS, APPEALS, QUESTIONNAIRES, DOCTOR REPORTS, DETERMINATIONS

I am the individual, to whom the requested information or 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 (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly 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 I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Standard Form 180 (Rev. 11/2015) (Page 1)
Prescribed by NARA (36 CFR 1233.18 (d))
Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 04/30/2018

REQUEST PERTAINING TO MILITARY RECORDS

Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/military-service-records/
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS *(Furnish as much information as possible.)*

1. NAME USED DURING SERVICE (last, first, full middle)	2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT *(For an effective records search, it is important that ALL service be shown below.)*

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE	-			☐	☐	
b. RESERVE	-			☐	☐	
c. STATE NATIONAL GUARD	-			☐	☐	

6. IS THIS PERSON DECEASED? ☐ NO ☐ YES - ***MUST*** *provide Date of Death if veteran is deceased:* _____

7. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☑ **DD Form 214 or equivalent.** Year(s) in which form(s) issued to veteran: _____

This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next-of-kin, or other persons or organizations, if authorized in Section III, below. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits**. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost.

An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a **DELETED** copy.

☑ **Medical Records** Includes Service Treatment Records, Health (outpatient) and Dental Records. ***IF HOSPITALIZED (inpatient)*** *the FACILITY NAME and DATE (month and year) for EACH admission* ***MUST*** *be provided:* _____

☐ **Other** (Specify): _____

2. PURPOSE: (Providing information about the purpose of the request is **strictly voluntary;** however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☑ Other (explain)

Explain here: LITIGATION REQUEST

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER NAME: LITIGATION MANAGEMENT INC.

2. ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section I, above.

☐ I am the DECEASED VETERAN'S NEXT-OF-KIN ***(MUST submit Proof of Death.*** *See item 2a on instruction sheet.)*

\-

(Relationship to deceased veteran)

☐ I am the VETERAN'S LEGAL GUARDIAN ***(MUST submit copy of Court Appointment)*** or AUTHORIZED REPRESENTATIVE ***(MUST submit copy of Authorization Letter or Power of Attorney)***

☑ OTHER DOCUMENT COLLECTION COMPANY

(Specify type of Other)

3. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

LITIGATION MANAGEMENT INC.
Name

6000 PARKLAND BOULEVARD
Street Apt.

MAYFIELD HEIGHTS OH 44124
City State Zip Code

* This form is available at ***http://www.archives.gov/veterans/military-service-records/standard-form-180.html*** on the National Archives and Records Administration (NARA) web site. *

4. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct and that I authorize the release of the requested information. *(See items 2a or 3a on accompanying instruction sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request if for archival records.)*

Signature Required - Do not print **Date**

Daytime phone Fax Number

Email address

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	Personnel Record	Medical or Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired 10/1/2004 – 12/31/2013	1	11
	Discharged, deceased, or retired on or after 1/1/2014	1	13
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, IRR, Retired Reserve in non-pay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	2	13
COAST GUARD	Discharge , deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired 4/1/1998 – 9/30/2006	14	11
	Discharged, deceased, or retired 10/1/2006 – 9/30/2013	3	11
	Discharged, deceased, or retired on or after 10/1/2013	3	14
	Active, Reserve, Individual Ready Reserve or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1895	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired 1/1/1999 - 12/31/2013	4	11
	Discharged, deceased, or retired on or after 1/1/2014	4	8
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	
	Discharged, deceased, or retired 10/16/1992 – 9/30/2002	14	11
	Discharged, deceased, or retired (including TDRL) 10/1/2002 – 12/31/2013	7	11
	Discharged, deceased, or retired (including TDRL) on or after 1/1/2014	7	9
	Current Soldier (Active, Reserve (including Individual Ready Reserve) or National Guard)	7	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired 1/1/1995 – 12/31/2013	10	11
	Discharged, deceased, or retired on or after 1/1/2014	10	8
	Active, Reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS and SELF-SERVICE WEBSITES (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1	Air Force Personnel Center HQ AFPC/DPSIRP 550 C Street West, Suite 19 Randolph AFB, TX 78150-4721	6	National Archives & Records Administration Research Services (RDT1R) 700 Pennsylvania Avenue NW Washington, DC 20408-0001	11	Department of Veterans Affairs Records Management Center ATTN: Release of Information P.O. Box 5020 St. Louis, MO 63115-5020
2	Air Reserve Personnel Center Records Management Branch (DPTSC) 18420 E. Silver Creek Avenue Building 390 MS 68 Buckley AFB, CO 80011	7	US Army Human Resources Command's web page: *https://www.hrc.army.mil/TAGD/Accessing%20or%20Requesting%20Your%20Official%20Military%20Personnel%20File%20Documents* or 1-888-ARMYHRC (1-888-276-9472)	12	Division of Commissioned Corps Officer Support ATTN: Records Officer 1101 Wooton Parkway, Plaza Level, Suite 100 Rockville, MD 20852
3	Commander, Personnel Service Center (BOPS-C-MR) MS7200 US Coast Guard 2703 Martin Luther King Jr Ave SE Washington, DC 20593-7200 *MR_CustomerService@uscg.mil*	8	Navy Medicine Records Activity (NMRA) BUMED Detachment St. Louis 4300 Goodfellow Boulevard, Building 103 St. Louis, MO 63120	13	AF STR Processing Center ATTN: Release of Information 3370 Nacogdoches Road, Suite 116 San Antonio, TX 78217
4	Headquarters U.S. Marine Corps Manpower Management Records & Performance (MMRP-10) 2008 Elliot Road Quantico, VA 22134-5030	9	AMEDD Record Processing Center 3370 Nacogdoches Road, Suite 116 San Antonio, TX 78217	14	National Personnel Records Center (Military Personnel Records) 1 Archives Drive St. Louis, MO 63138-1002 *e*VetRecs: *http://www.archives.gov/veterans/military-service-records/*
5	Marine Forces Reserve 2000 Opelousas Avenue New Orleans, LA 70146-5400	10	Navy Personnel Command (PERS-313) 5720 Integrity Drive Millington, TN 38055-3120		

AMENDED*

EXHIBIT C

*Amended 8/16/18

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW HAMPSHIRE

IN RE:	)	**MDL NO. 2753**
ATRIUM MEDICAL CORP. C-QUR MESH PRODUCTS LIABILITY LITIGATION	)	**MDL Docket No. 1:16-md-02753-LM**
	)	**ALL CASES**

PLAINTIFF FACT SHEET

Each plaintiff who allegedly suffered injury as a result of a C-QUR™ Mesh Product must complete this Plaintiff Fact Sheet. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. Please answer every question to the best of your knowledge. Do not leave any blanks throughout this Fact Sheet. 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 you do not have room in the space provided to complete an answer, please attach as many sheets of paper as necessary to fully answer the questions set out below. If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/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 responses pursuant to Federal Rules of Civil Procedure 33 and 34, and will be governed by the standards applicable to written discovery under Federal Rules of Civil Procedure 26 through 37.

You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. Should you need to correct or supplement any response made here, please contact your attorneys, and they will assist you in doing so.

I. CASE INFORMATION

A. Name of person who received C-QUR™ Mesh: _____

_____

B. Name of Plaintiff (if different from above): _____

_____

C. Provide the following information for the lawsuit that has been filed:

1. Case caption: _____

_____

2. Civil action number:_____

3. Court where case was originally filed or would have been filed absent direct filing into this MDL: _____

_____

D. If the person completing this Fact Sheet is doing so in a representative capacity (*e.g.*, on behalf of the estate of a deceased person, or on behalf of a minor), please provide the following (**otherwise skip to Section II**):

1. Your current address:_____

_____

2. State in what capacity you are representing the individual or estate (for example, as executor, as personal representative, etc.):

_____

3. If you were appointed as a representative by a court, then state:

a. Court that appointed you: _____

_____

b. Date of appointment:_____

4. If you represent a decedent's estate, then state:

a. Decedent's date of death:_____

b. Home address of decedent at time of death:_____

_____

c. Your relationship to the deceased or represented person:_____

d. If you represent a decedent, please attach a copy of the decedent's death certificate and autopsy report.

E. Name, address, telephone number, fax number and email address of principal attorney representing you:

Name:_____

Firm: _____

Address:_____

Telephone Number:_____ Fax Number:_____

E-mail Address:_____

THE REST OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO RECEIVED THE C-QUR™ MESH PRODUCT. Those questions using the term "You" refer to the person who received the C-QUR™ Mesh Product. Therefore, if you are completing this questionnaire in a representative capacity, please respond to the remaining questions as if they are asking about the person who received the C-QUR™ Mesh Product. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.

II. PERSONAL INFORMATION

A. Prefix (Mr., Ms., Rev., Dr., etc.): _____ / First name: _____

Last name: _____ / Suffix (Sr., Jr., etc.): _____

Middle name: _____

Maiden name (if any): _____

B. Other names by which you have been known (from prior marriages or otherwise): _____

_____

C. Male _____ Female _____

D. Social Security number: _____

E. Date and place of birth: _____

F. Present home address:_____

_____

1. How long have you lived at this address? _____

_____

2. Identify family members who currently reside with you:_____

_____

_____

G. Identify each prior home address where you have lived during the last ten (10) years:

Prior Address	**Dates You Lived At This Address**

H. Are you currently married? Yes_____ No_____

If Yes, please provide:

1. Spouse's name: _____
2. Spouse's date of birth: _____
3. Spouse's occupation: _____
   _____
4. Date of marriage: _____
5. Were you married before this:

   Yes _____ No_____

   If Yes, please tell us:

   i. Spouse's name:_____

   ii. Approximate dates of the marriage: _____

   iii. Result of the marriage: _____

I. Identify all schools you attended, starting with high school:

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

J. Please provide the following information for your employment history over the past ten (10) years:

Employer/Company	Address	Occupation/ Job Title	Dates of Employment

K. Have you ever missed work for more than ten (10) consecutive days for reasons related to your health? Yes _____ No_____

If no, skip to Part II.L., below.
If yes:

1. Provide the dates of your absence from work: _____
_____

2. Identify by name and address your employer at that time: _____
_____
_____

3. Describe the health condition that prevented you from working, including whether/how the condition resolved such that you were allowed to return to work:
_____
_____
_____
_____
_____

L. Have you ever served in any branch of the military? Yes _____ No_____

If no, skip to Part II.M, below.
If yes:

1. Branch and dates of service:_____

2. If Yes, were you ever discharged for any reason relating to your medical, physical, or psychiatric condition?_____

3. If Yes, state what that condition was:_____
_____

M. Have you ever been rejected from military service for any reason relating to your health or physical condition? Yes _____ No_____

If no, skip to Part II.N, below.
If yes:

1. Describe the reason(s) you were rejected from military service. _____
_____
_____
_____

N. Have you ever been convicted of, or pled guilty to, a felony and/or crime of fraud or dishonesty? Yes _____ No_____

If no, skip to Part III, below.
If yes:

1. Please set forth where, when and the felony and/or crime. _____

_____
_____
_____

III. CLAIM INFORMATION

A. Did you receive a C-QUR™ Mesh Product? Yes _____ No_____

I Don't Know _____

If no, state what product you did receive that you claim injured you, and answer all subsequent questions as if they referred to that product rather than to a C-QUR™ Mesh Product.

If yes, or if you do not know for sure whether you received a C-QUR™ Mesh Product, please give the following information for each C-QUR™ Mesh Product you received or believe you may have received (attach additional sheets as necessary):

1. The date the C-QUR™ Mesh Product was implanted in you: _____

2. Provide the size, product code or model number, and lot number of the C-QUR™ Mesh Product you received (NOTE that a traceability label that clearly identifies the product code and lot number usually accompanies any C-QUR™ Mesh Product and will be affixed to your surgeon's "Op Report" or surgical notes): _____
_____
_____

3. Describe the medical condition for which you received the C-QUR™ Mesh Product: _____
_____
_____
_____

4. Identify who diagnosed you with that medical condition: _____
_____
_____

5. Identify the doctor and hospital or other facility that implanted the C-QUR™ Mesh Product: _____
_____
_____
_____

6. Prior to implantation, were you given any written or verbal warnings, instructions, or other information regarding the C-QUR™ Mesh Product and/or potential complications of your surgery? Yes _____ No_____ I Don't Know_____

If yes:

a. Provide the date you received the warnings, instructions, or other information:_____

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

c. What warnings, instructions, or other information did you receive?

d. If you received written warnings, instructions, or other information, including but not limited to any type of consent form that you signed before your surgery, do you possess a copy of said warnings, instructions, or other information? _____

7. Was the C-QUR™ Mesh Product that you received explanted or removed in whole or in part? Yes _____ No_____ I Don't Know _____

If no, skip to Part III.A.8., below.
If yes:

a. Did a medical doctor advise you to have the C-QUR™ Mesh Product or any part of it removed prior to the actual explant?
Yes _____ No_____ I Don't Know _____

If yes:

i. Provide the date that any doctor advised you to have the C-QUR™ Mesh Product or any part of it removed: _____

ii. What reason did the doctor give for his/her recommendation that the C-QUR™ Mesh Product be removed? _____

iii. Identify by name and address the doctor who advised you to have the C-QUR™ Mesh Product or any part of it removed:_____

_____
_____
_____
_____

b. If **NO DOCTOR ADVISED** that you have the C-QUR™ Mesh Product removed prior to the removal procedure, explain why you had the C-QUR™ Mesh Product or any part of it removed: _____
_____
_____
_____
_____
_____
_____

c. Provide the date(s) the C-QUR™ Mesh Product or any part of it was removed: _____
_____
_____

d. Identify by name and address the doctor, hospital, or other facility that explanted or removed any part of the C-QUR™ Mesh Product:_____
_____
_____
_____
_____
_____

e. Do you know where your explanted C-QUR™ Mesh Product currently is: Yes _____ No_____

If yes:

i. Please identify who is in possession of your explanted C-QUR™ Mesh Product: _____
_____

If No:

i. Do you know whether your C-QUR™ Mesh Product was destroyed? Yes _____ No_____ I Don't Know _____

If Yes, please tell us how you know and who destroyed it: ___
_____
_____

f. Has the explanted C-QUR™ Mesh Product or other material been returned to Atrium Medical Corporation?

Yes _____ No_____ I Don't Know _____

If yes:

i. Provide the date the C-QUR™ Mesh Product or other materials were returned: _____

_____

ii. Identify by name and address the person(s) who returned the explanted C-QUR™ Mesh Product or other materials:

_____

_____

_____

_____

iii. Identify by name and address the person(s) who received the explanted C-QUR™ Mesh Product or other materials:

_____

_____

_____

_____

8. **IF YOUR C-QUR™ MESH PRODUCT HAS <u>NOT</u> BEEN EXPLANTED**, please answer the following questions.

a. Has any doctor or other health care practitioner advised you to have the C-QUR™ Mesh Product removed? Yes _____ No _____

If yes:

i. Provide the date that any doctor advised you to have the C-QUR™ Mesh Product or any part of it removed: _____

_____

_____

ii. What reason did the doctor give for his/her recommendation that the C-QUR™ Mesh Product be removed? _____

_____

_____

_____

iii. Identify by name and address the doctor who advised you to have the C-QUR™ Mesh Product or any part of it removed: _____

_____

_____

_____

_____

iv. Why have you not had the C-QUR™ Mesh Product removed?

_____

_____

_____

_____

b. Has any doctor or other health care practitioner advised you not to have the C-QUR™ Mesh Product removed? Yes _____ No _____

If yes:

i. Identify by name and address any doctor or other health care practitioner who has advised you not to have the C-QUR™ Mesh Product removed: _____

_____

_____

_____

ii. Provide the date you were so advised: _____

iii. What reason did the doctor give for his/her recommendation that the C-QUR™ Mesh Product not be removed? _____

_____

_____

_____

_____

_____

_____

c. Do you intend to have the C-QUR™ Mesh Product removed?

Yes _____ No_____ I Don't Know _____

If yes:

i. Provide the approximate date when it will be removed:_____

_____

ii. Identify by name and address the doctor, hospital, or other facility that will perform the explant surgery: _____
_____
_____
_____

B. Do you claim that you suffered physical and/or bodily injury or symptoms resulting from your use of the C-QUR™ Mesh Product? Yes _____ No_____

If no, skip to Part III.C., below.
If yes, provide the following information:

Description of Bodily Injury	**Approx. Date of Onset**	**Approx. Date of Medical Attention**	**Treating Physician and Treatment Rendered**

1. Provide the date that you believed that any of the above bodily injuries were caused by the C-QUR™ Mesh Product that you received: _____
_____
_____

2. Has any doctor attributed the above bodily injuries to your use of or any defect in the C-QUR™ Mesh Product? Yes _____ No_____ I Don't Know _____

If yes:

a. Provide the date that a doctor or other health care practitioner first advised you that these bodily injuries or symptoms were caused by the C-QUR™ Mesh Product that you received: _____

_____

_____

b. Identify by name and address the doctor, hospital, or other facility that attributed these bodily injuries or symptoms to your C-QUR™ Mesh Product: _____

_____

_____

_____

_____

C. Do you claim to have suffered any emotional distress or psychological injuries from your implantation of the C-QUR™ Mesh Product, and any pain and suffering you may have experienced as a result of this implant?

Yes _____ No_____

D. Are you are currently seeing, or have you seen, a psychiatrist, psychologist or any other mental healthcare professional as a result of your implantation of the C-QUR™ Mesh Product.

Yes _____ No_____

If no, skip to Part III.E., below.
If yes:

1. Describe your psychiatric and/or psychological injuries: _____

_____

_____

_____

_____

_____

_____

2. Provide the date(s) that these injuries occurred: _____

_____

3. Provide the date that you believed that these injuries were caused by the C-QUR™ Mesh Product that you received: _____

_____

4. Provide the following information for any doctor, psychiatrist, psychologist, or other mental health professional who has treated you or is now treating and/or advising you about your injuries:

   a. Dates of treatment: _____

   b. Name: _____
   _____

   c. Address: _____
   _____
   _____

5. Has any doctor, psychiatrist, psychologist, or other mental health professional attributed these injuries to the C-QUR™ Mesh Product?

   Yes _____ No_____ I Don't Know _____

   If no, skip to Part III.E., below.
   If yes:

   a. Provide the date that a doctor or other health care practitioner first advised you that these injuries were caused by the C-QUR™ Mesh Product that you received: _____

   b. Identify by name and address the doctor, hospital, or other facility that attributed these injuries to your C-QUR™ Mesh Product: _____
   _____
   _____
   _____

E. Do you claim that you have experienced lost wages or lost earning capacity resulting from your use of the C-QUR™ Mesh Product? Yes _____ No_____

If no, skip to Part III.F., below.
If yes:

1. Identify the employer: _____
_____

2. State the total amount of time which you have lost from work as a result of the injuries you believe were caused by your use of the C-QUR™ Mesh Product:
_____
_____
_____

3. State the total amount of lost income: _____
_____

[Attach additional sheets as necessary to provide the same information for any other lost income or lost earning capacity for any additional employers.]

F. Have you expended any out-of-pocket expenses as a result of your C-QUR™ Mesh Product?

Yes _____ No_____

If yes:

1. Please identify and itemize all out-of-pocket expenses you have incurred:
_____
_____
_____
_____

G. Was any portion of your surgery or any other medical procedures relating to your surgery covered by health insurance, Medicare or Medicaid?

Yes _____ No_____

If yes:

1. Please identify all insured or covered expenses:
_____
_____
_____
_____

H. Has anyone filed a loss of consortium claim in connection with your lawsuit regarding the C-QUR™ Mesh Product? Yes _____ No_____

If no, skip to Part IV, below.
If yes:

1. Identify by name and address the person who filed the loss of consortium claim:

_____

_____

_____

2. State that person's relationship to you: _____

IV. PRIOR CLAIM INFORMATION

A. Have you ever filed a lawsuit other than the present suit, relating to any bodily injury within the past ten (10) years? Yes _____ No_____

If Yes, please explain the nature of the case, where it was filed, and identify your lawyer:

_____

_____

_____

_____

B. Have you applied for workers' compensation, social security, or state or federal disability benefits within the past **ten (10)** years? Yes _____ No_____

If Yes, then as to each application, separately state:

1. Date (or year) of application: _____

2. Type of benefits: _____

3. Nature of claimed injury/disability: _____

4. Period of disability: _____

5. Amount awarded:_____

6. Basis of your claim:_____

7. Was claim denied? Yes _____ No_____

8. To what agency or company did you submit your application:

_____

9. Claim/docket number, if applicable:_____

V. MEDICAL BACKGROUND

A. Provide your current: Age _____ / Height _____ / Weight _____

B. At the time you received the C-QUR™ Mesh Product, please state:
Your age _____ / Your approximate weight _____

C. In chronological fashion, describe any and all prior surgeries BEFORE implantation of the C-QUR™ Mesh Product; identify by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved with each surgery; and provide the corresponding date(s) or timeframe(s) for each:

Approx. Date	Description of Surgery	Doctor or Healthcare Provider Involved

[Attach additional sheets as necessary to provide the same information for any and all surgeries leading up to implantation of the C-QUR™ Mesh Product.]

D. In chronological fashion, describe any and all surgeries or procedures you have undergone AFTER receiving the C-QUR™ Mesh Product; identify by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved with each surgery or procedure; and provide the corresponding date(s) or timeframe(s) for each:

Approx. Date	**Description of Surgery**	**Doctor or Healthcare Provider Involved**

[Attach additional sheets as necessary to provide the same information for any and all surgeries subsequent to implantation of the C-QUR™ Mesh Product.]

E. To the extent not already provided in the charts at Part V.C. and Part V.D., 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 ten (10) years, with the exception of psychiatrists, psychologists, or mental healthcare professionals:

Name and Specialty	Address	Approx. Dates/Years of Visits

F. To the best of your knowledge, have you ever been told by a doctor or any other health care provider, that you have suffered, may have suffered, or presently do suffer from any of the following:

1.	Hernias (other than the one you had repaired with the C-QUR™ Mesh Product)	Yes _____ No _____
2.	Recurrent Hernia(s)	Yes _____ No _____
3.	Recurrent or Chronic Infections	Yes _____ No _____
	Specify location and nature of infection: _____	
4.	Fistulas	Yes _____ No _____
5.	Adhesions	Yes _____ No _____
6.	Bowel Obstruction	Yes _____ No _____
7.	Bowel Perforation	Yes _____ No _____
8.	Peritonitis/Sepsis	Yes _____ No _____
9.	Malnutrition	Yes _____ No _____
10.	Anemia	Yes _____ No _____
11.	Chronic Obstructive Pulmonary Disease (COPD)	Yes _____ No _____
12.	Emphysema	Yes _____ No _____
13.	Connective Tissue Disorder	Yes _____ No _____
14.	Collagen Disorder	Yes _____ No _____
15.	Aneurysm	Yes _____ No _____
16.	Muscle or Muscle-Wasting Disorder	Yes _____ No _____
	Specify condition:	
17.	Hypertension or high blood pressure	Yes _____ No _____
18.	Hypotension or low blood pressure	Yes _____ No _____
19.	Obesity	Yes _____ No _____
20.	Heart Attack or Congestive Heart Failure	Yes _____ No _____

21. Stroke Yes _____ No _____

22. Diabetes Yes _____ No _____

23. Thyroid dysfunction Yes _____ No _____

24. Crohn's disease Yes _____ No _____

25. Irritable bowel syndrome Yes _____ No _____

26. Diverticulitis Yes _____ No _____

27. Any other disease of the gut, intestines, or bowel Yes _____ No _____

Specify condition:_____

28. Neuromuscular disease or disorder Yes _____ No _____

Specify condition:_____

29. Immune system disease or dysfunction Yes _____ No _____

If yes, specify:_____

30. Any alcohol or chemical dependency addiction Yes _____ No _____

If yes, specify: _____

31. Any history of tobacco use Yes _____ No _____

If yes, specify type (cigarettes, cigars, chewing tobacco), frequency, when started and when quit, if applicable: _____

If you responded "yes" to any of the above, for each condition, please provide the following information, attaching additional sheets as needed:

i. Condition: _____

1. Date of onset: _____

2. Date of diagnosis: _____

3. Person making diagnosis: _____

_____

4. Type of treatment (including but not limited to medication amount and/or dosage): _____

_____

_____

_____

G. To the extent not previously disclosed in response to Part V.F., above, list each prescription medication you have taken regularly for the past ten (10) years. Please include the reason you took the medication, and the dosage.

Medication	**Dosage**	**Reason for Medication**

VI. INSURANCE INFORMATION

A. Provide the following information for any past or present medical insurance coverage within the last ten (10) years:

Name of Insurance Company	Policy Number	Name of Policy Holder/Insured (if different than you)	Approx. Dates of Coverage

B. Have you ever been denied life insurance for reasons relating to your health?

Yes _____ No_____ I Don't Know _____

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

VII. COMMUNICATIONS WITH DEFENDANTS

A. Have you or anyone acting on your behalf that you are aware of, other than your attorney, ever communicated directly with Atrium Medical Corporation or Maquet Cardiovascular US Sales, LLC in any way concerning the C-QUR™ Mesh Product?

Yes _____ No_____ I Don't Know _____

If no, skip to Part VII.B., below.
If yes:

1. Provide the date of any communication: _____

2. Identify by name and address the person making the communication: _____
_____
_____

3. Identify by name and address the person with whom you (or anyone else) communicated at Atrium Medical Corporation or Maquet Cardiovascular US Sales, LLC: _____
_____
_____

4. Describe the method of communication (e.g., telephone, letter, e-mail, etc.): _____
_____
_____

5. Describe the substance of the communication: _____
_____
_____
_____

B. Have you or anyone acting on your behalf, that you are aware of, other than your attorney ever received a communication directly from Atrium Medical Corporation or Maquet Cardiovascular US Sales, LLC in any way concerning the C-QUR™ Mesh?

Yes _____ No_____ I Don't Know _____

If no, skip to Part VIII, below.
If yes:

1. Provide the date of any communication: _____

2. Identify by name and address the person with Atrium Medical Corporation or Maquet Cardiovascular US Sales, LLC making the communication: _____
_____
_____

3. Identify by name and address the person to whom the communication from Atrium Medical Corporation or Maquet Cardiovascular US Sales, LLC was directed: ____
_____
_____

4. Describe the method of communication (*e.g.*, telephone, letter, e-mail, etc.):
_____
_____

5. Describe the substance of the communication from Atrium Medical Corporation or Maquet Cardiovascular US Sales, LLC: _____
_____
_____
_____

VIII. INJURIES/DAMAGES

A. Are you claiming any injury as a result of your use of the C-QUR™ Mesh Product?

Yes _____ No_____

If Yes:

1. Please describe in detail your physical injury(ies) you claim were caused as result of your use of C-QUR™ Mesh Product:

_____

_____

_____

_____

_____

_____

_____

_____

IX. POTENTIAL WITNESSES

A. 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 (Attach Additional Sheets if Necessary):

Name:_____

Address:_____

_____

Relationship to you: _____

Name:_____

Address:_____

_____

Relationship to you: _____

Name: _____

Address:_____

_____

Relationship to you:_____

X. AUTHORIZATIONS FOR RECORDS & DOCUMENT PRODUCTION

A. **AUTHORIZATIONS.**

NOTE: Please sign and attach to this Fact Sheet the authorization for the release of records appended hereto.

B. **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.

1. 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 _____

2. If you represent the estate of a deceased person in this lawsuit, produce a copy of the decedent's death certificate.

i. Not Applicable _____

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

3. Produce all documents in your possession, custody or control concerning any occasion on which you saw a doctor or other health care provider regarding any injury or physical or psychological complaint for which you claim compensation in this lawsuit, including but not limited to all medical reports and records; psychological assessments and records; and laboratory findings and reports.

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

4. Produce all medical and hospital bills or receipts, and documents in your possession, custody or control reflecting any and all payments made for same, including, but not limited to, any hospital and health care professional bills incurred because of the injuries you allege you have incurred as a result of your use of the C-QUR™ Mesh.

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

5. Produce any communications in your possession, custody or control, excluding communications with your lawyers, concerning the C-QUR™ Mesh, including but not limited to e-mails, blogs, newsletters, etc.

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

6. Produce any notes, diaries, or other documents evidencing your physical or mental condition, including but not limited to the injuries for which you claim relief in this lawsuit.

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

7. Produce any C-QUR™ Mesh packaging, labeling, advertising, or any other C-QUR™ Mesh-related items in your possession, custody or control.

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

8. Produce all documents in your possession, custody or control evidencing or relating to any correspondence or communication between Atrium Medical Corporation and any of your doctors, healthcare providers, and/or you relating to the C-QUR™ Mesh.

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

9. Produce any and all documents in your possession, custody or control relating to the recall of the C-QUR™ Mesh that you received and/or reviewed at any time prior to filing this lawsuit.

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

10. 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 the C-QUR™ Mesh concerning the risks and/or benefits of your hernia repair surgery, including but not limited to any risks and/or benefits associated with the C-QUR™ Mesh.

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

11. Produce any and all documents reflecting the size, model number, and lot number of the C-QUR™ Mesh you received.

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

12. If you underwent surgery to explant in whole or in part the C-QUR™ Mesh that you received, produce any and all documents in your possession, custody or control relating to any evaluation of the C-QUR™ Mesh and any other material that was(were) surgically removed from you.

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

13. Produce all documents in your possession, custody or control relating to any and all workers compensation claims made by you.

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

14. Produce all documents in your possession, custody or control relating to any bankruptcy matters to which you were a party.

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

SWORN DECLARATION

Plaintiff, _____, deposes and states as follows:

I declare under penalty of perjury that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief; I have supplied all the documents requested in Part X of this Fact Sheet to the extent that such documents are in my possession, custody, or control; and I have supplied the records authorizations requested in and attached to this Fact Sheet.

Dated: _____ _____

Signature

Appendix A

(Authorization Forms)

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL AND HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO: _____

Patient Name: _____

DOB: _____

SSN: _____

I,_____, hereby authorize you to release and furnish to: Litigation Management Inc. ("LMI"), 6000 Parkland Blvd., Mayfield Hts., OH 44124) COPIES ONLY of the following information:

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

1. To my medical provider: this authorization is being forwarded by, or on behalf of, attorneys for the parties to civil litigation. This authorization is construed to permit agents or designees of LMI and/or the parties to copy, inspect and review any and all such records.

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to LMI at the above address. 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 upon resolution of the litigation, through and including any appellate disposition.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I have a right to a copy of same. 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 re-disclosure and the information may not be protected by federal confidentiality rules. If 1 have questions about disclosure of my health information, I can contact the releaser indicate above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name: _____(plaintiff/representative)

Signature: _____ _____
Date

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;

Social Security Administration; and

Department of the Treasury/Internal Revenue Service;

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 Litigation Management, Inc. ("LMI") 6000 Parkland Boulevard, Mayfield Heights, OH 44124 and its authorized representatives, with 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 concerning C-Qur™ hernia mesh.

- 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 either Litigation Management Inc. (6000 Parkland Boulevard, Mayfield Heights, OH 44124) 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 furnished to LMI, pursuant to this authorization will be shared with any and all of the attorneys for the parties in the C-Qur™ hernia mesh litigation 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 later of: (i) the date of settlement or final disposition of undersigned's Q-Qur™ hernia mesh litigation.

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to Litigation Management, Inc. 6000 Parkland Boulevard, Mayfield Heights, OH 44124, and its authorized representatives, by any entities included in the categories listed above.

Date:_____ _____

Signature of Individual or Individual's Representative

Printed Name of Individual's Representative (If applicable) _____

_____

Relationship of Representative to 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 FOR RELEASE OF EDUCATIONAL RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of all school records including, but not limited to, test results, test scores, report cards, or other school grading material, attendance records, physicals and other health-related, including but not limited to any physicians, nursing or allied health professional reports, records or notes, which may be in your possession.

_____
Name of Student

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

You are authorized to release the above records to Litigation Management Inc. (6000 Parkland Boulevard, Mayfield Heights, OH 44124 who have agreed to pay reasonable charges made by you to supply copies of such records.

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: _____ _____
Student/Name

HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508
EMPLOYMENT AUTHORIZATION

TO: _____
Name of Employer

_____
Address, City State and Zip Code

RE: Employee Name: _____ aka _____

Date of Birth: _____Social Security Number: _____

Address: _____

I authorize the disclosure of my employment records including any medical information protected by HIPAA, 45 CFR 164.508, for the purpose of review and evaluation in connection with a legal claim. I expressly request that all entities identified above disclose full and complete records including the following:

This will authorize you to furnish copies of all applications for employment; resumes; records of all positions held; job descriptions of positions held; wage and income statements and/or compensation records; wage increases and decreases; performance evaluations, reviews and reports; transfers, statements and comments of fellow employees; all documents relating to discipline including warnings, reprimands, suspensions, terminations, and all other forms of discipline; attendance records; W-2s, worker's compensation files; all medical records, x- rays and test results; any physical examination records; all documents relating to my absences, illnesses and injuries; any records pertaining to claims made relating to health, disability or accidents in which 1 was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf; and any other records relating to my employment and/or in my personnel file. Information about HIV/AIDS and alcohol/substance abuse may be disclosed.

I authorize you to release the information to; Litigation Management Inc. (6000 Parkland Boulevard, Mayfield Heights, OH 44124.

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requestor at that time.

I acknowledge the right to revoke this authorization by writing to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the

entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization expires upon the resolution of my litigation, through and including any appellate disposition, concerning C-Qur™ hernia mesh.

_____

Signature of Employee or Personal Representative

_____

Name of Employee or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority to Sign for Employee (attach documents that show authority)

AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS

To: _____
Name

_____
Address

_____
City, Slate and Zip Code

This will authorize you to furnish copies of all forms regarding insurance claims applications and benefits and all medical, health, hospital, physicians, nursing or allied health professional reports, records, notes or invoices and bills, which may be in your possession.

_____
Name of Insured

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

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records: Litigation Management Inc. (6000 Parkland Boulevard, Mayfield Heights, OH 44124.

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, if 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.

_____ _____
Name/Signature Date

Form **4506-T**
(July 2017)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ _____

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☑

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

12 / 31 / 2016	12 / 31 / 2015	12 / 31 / 2014	12 / 31 / 2013

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ _____ _____
Signature (see instructions) Date

▶ _____
Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ _____
Spouse's signature Date

Form **4506-T**
(July 2017)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

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OMB No. 1545-1872

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1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ _____

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☑

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

12 / 31 / 2012	12 / 31 / 2011	12 / 31 / 2010	12 / 31 / 2009

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) — Date

▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** — Date

Form **4506-T**
(July 2017)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

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OMB No. 1545-1872

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1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ _____

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b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

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9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

12 / 31 / 2008	12 / 31 / 2007	12 / 31 / 2006	/ /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ _____ _____ _____
Signature (see instructions) Date

▶ _____
Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ _____
Spouse's signature Date

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

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

***NAME OF PERSON OR ORGANIZATION:**

LITIGATION MANAGEMENT INC.

***ADDRESS OF PERSON OR ORGANIZATION:**

6000 PARKLAND BOULEVARD

MAYFIELD HEIGHTS, OHIO 44124

***I want this information released because:** LITIGATION REQUEST

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☒ Current monthly Social Security benefit amount
3. ☒ Current monthly Supplemental Security Income payment amount
4. ☒ My benefit or payment amounts from date 2007 to date 2017
5. ☒ My Medicare entitlement from date 2007 to date 2017
6. ☒ Medical records from my claims folder(s) from date 2007 to date 2017

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☒ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

   CONSULTATIVE EXAMS, AWARD/DENIAL NOTICES, BENEFIT APPLICATIONS, APPEALS, QUESTIONNAIRES, DOCTOR REPORTS, DETERMINATIONS

I am the individual, to whom the requested information or 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 (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly 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 I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Standard Form 180 (Rev. 11/2015) (Page 1)
Prescribed by NARA (36 CFR 1233.18 (d))
Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 04/30/2018

REQUEST PERTAINING TO MILITARY RECORDS

Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/military-service-records/
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS *(Furnish as much information as possible.)*

1. NAME USED DURING SERVICE (last, first, full middle)	2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT *(For an effective records search, it is important that ALL service be shown below.)*

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE	-			☐	☐	
b. RESERVE	-			☐	☐	
c. STATE NATIONAL GUARD	-			☐	☐	

6. IS THIS PERSON DECEASED? ☐ NO ☐ YES - ***MUST*** *provide Date of Death if veteran is deceased:* _____

7. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☑ **DD Form 214 or equivalent.** Year(s) in which form(s) issued to veteran: _____

This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next-of-kin, or other persons or organizations, if authorized in Section III, below. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits**. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost.

An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a **DELETED** copy.

☑ **Medical Records** Includes Service Treatment Records, Health (outpatient) and Dental Records. ***IF HOSPITALIZED (inpatient)*** *the FACILITY NAME and DATE (month and year) for EACH admission* ***MUST*** *be provided:* _____

☐ **Other** (Specify): _____

2. PURPOSE: (Providing information about the purpose of the request is **strictly voluntary;** however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☑ Other (explain)

Explain here: LITIGATION REQUEST

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER NAME: LITIGATION MANAGEMENT INC.

2. ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section I, above.

☐ I am the DECEASED VETERAN'S NEXT-OF-KIN ***(MUST submit Proof of Death.*** *See item 2a on instruction sheet.)*

\-

(Relationship to deceased veteran)

3. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

LITIGATION MANAGEMENT INC.
Name

6000 PARKLAND BOULEVARD
Street Apt.

MAYFIELD HEIGHTS OH 44124
City State Zip Code

* This form is available at ***http://www.archives.gov/veterans/military-service-records/standard-form-180.html*** on the National Archives and Records Administration (NARA) web site. *

☐ I am the VETERAN'S LEGAL GUARDIAN ***(MUST submit copy of Court Appointment)*** or AUTHORIZED REPRESENTATIVE ***(MUST submit copy of Authorization Letter or Power of Attorney)***

☑ OTHER DOCUMENT COLLECTION COMPANY
(Specify type of Other)

4. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct and that I authorize the release of the requested information. *(See items 2a or 3a on accompanying instruction sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request if for archival records.)*

Signature Required - Do not print **Date**

Daytime phone Fax Number

Email address

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	Personnel Record	Medical or Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired 10/1/2004 – 12/31/2013	1	11
	Discharged, deceased, or retired on or after 1/1/2014	1	13
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, IRR, Retired Reserve in non-pay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	2	13
COAST GUARD	Discharge , deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired 4/1/1998 – 9/30/2006	14	11
	Discharged, deceased, or retired 10/1/2006 – 9/30/2013	3	11
	Discharged, deceased, or retired on or after 10/1/2013	3	14
	Active, Reserve, Individual Ready Reserve or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1895	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired 1/1/1999 - 12/31/2013	4	11
	Discharged, deceased, or retired on or after 1/1/2014	4	8
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	
	Discharged, deceased, or retired 10/16/1992 – 9/30/2002	14	11
	Discharged, deceased, or retired (including TDRL) 10/1/2002 – 12/31/2013	7	11
	Discharged, deceased, or retired (including TDRL) on or after 1/1/2014	7	9
	Current Soldier (Active, Reserve (including Individual Ready Reserve) or National Guard)	7	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired 1/1/1995 – 12/31/2013	10	11
	Discharged, deceased, or retired on or after 1/1/2014	10	8
	Active, Reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS and SELF-SERVICE WEBSITES (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1	Air Force Personnel Center HQ AFPC/DPSIRP 550 C Street West, Suite 19 Randolph AFB, TX 78150-4721	6	National Archives & Records Administration Research Services (RDT1R) 700 Pennsylvania Avenue NW Washington, DC 20408-0001	11	Department of Veterans Affairs Records Management Center ATTN: Release of Information P.O. Box 5020 St. Louis, MO 63115-5020
2	Air Reserve Personnel Center Records Management Branch (DPTSC) 18420 E. Silver Creek Avenue Building 390 MS 68 Buckley AFB, CO 80011	7	US Army Human Resources Command's web page: *https://www.hrc.army.mil/TAGD/Accessing%20or%20Requesting%20Your%20Official%20Military%20Personnel%20File%20Documents* or 1-888-ARMYHRC (1-888-276-9472)	12	Division of Commissioned Corps Officer Support ATTN: Records Officer 1101 Wooton Parkway, Plaza Level, Suite 100 Rockville, MD 20852
3	Commander, Personnel Service Center (BOPS-C-MR) MS7200 US Coast Guard 2703 Martin Luther King Jr Ave SE Washington, DC 20593-7200 *MR_CustomerService@uscg.mil*	8	Navy Medicine Records Activity (NMRA) BUMED Detachment St. Louis 4300 Goodfellow Boulevard, Building 103 St. Louis, MO 63120	13	AF STR Processing Center ATTN: Release of Information 3370 Nacogdoches Road, Suite 116 San Antonio, TX 78217
4	Headquarters U.S. Marine Corps Manpower Management Records & Performance (MMRP-10) 2008 Elliot Road Quantico, VA 22134-5030	9	AMEDD Record Processing Center 3370 Nacogdoches Road, Suite 116 San Antonio, TX 78217	14	National Personnel Records Center (Military Personnel Records) 1 Archives Drive St. Louis, MO 63138-1002 *e*VetRecs: *http://www.archives.gov/veterans/military-service-records/*
5	Marine Forces Reserve 2000 Opelousas Avenue New Orleans, LA 70146-5400	10	Navy Personnel Command (PERS-313) 5720 Integrity Drive Millington, TN 38055-3120		

EXHIBIT D

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW HAMPSHIRE

IN RE:	)	**MDL NO. 2753**
ATRIUM MEDICAL CORP. C-QUR MESH PRODUCTS LIABILITY LITIGATION	)	**MDL Docket No. 1:16-md-02753-LM**
	)	**ALL CASES**

[EACH] DEFENDANT'S PROFILE FORM

For each case, Defendants must separately complete this Profile Form. Except as otherwise set forth in any Order, this Profile Form must be completed and served on Plaintiffs' counsel in each individual case within sixty (60) days of receiving Plaintiffs' Profile Form.

I. CASE INFORMATION

This Defendant Profile Form pertains to the following case:
Case Name:
Docket number:

II. CONTACTS WITH TREATING AND EVALUATING PHYSICIANS

Plaintiff has identified each physician who treated and/or evaluated Plaintiff for hernia repair and/or associated conditions that led to the use of Defendants' hernia mesh products where each treatment occurred. As to each employee or agent of Defendant who had any contact with an identified physician in the PPF, set forth the following:

A. Identity of physician.

B. Identity and last known address and telephone number of the individual along with their title.

C. The work history with Defendant and known current relationship, if any, between the specified Defendant(s) and the individual.

D. Identity of the individual's supervisor(s) during his/her employment.

E. A description of each of the contacts between the individual(s) and the Physician.

F. Set forth the date, and location of each operation or procedure performed on the Plaintiff, which was attended at all by the individual.

G. State whether the individual has ever been investigated, reprimanded, and/or otherwise penalized by any person, entity, or government agency for his/her sales or marketing practices relating to C-Qur hernia mesh, and if so set forth the details thereof.

III. INFORMATION REGARDING THE PLAINTIFF

A. Identify all data, information, objects, and reports in Defendant's possession or control or which have been reviewed or analyzed by Defendant, with regard to the Plaintiff's medical condition(s), as specifically related to that Plaintiff. The timeframe applicable to this request is limited to any such review or analysis conducted before the filing of Plaintiff's action. Work product is specifically excluded from this request.

B. Identify all data, information, objects, and reports, study or research in Defendant's possession or control or which have been reviewed or analyzed by Defendant, with regard to Plaintiff's specific implant or associated lot number. The timeframe applicable to this request is limited to any such review or analysis conducted before the filing of Plaintiff's action. Work product is specifically excluded from this request.

C. Identify any contact or communication, either written or oral, between the Plaintiff and any employee or representative of Defendant concerning C-Qur hernia mesh, including but not limited to pre-operative inquiries, and post-operative complaints.

D. 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 concerning C-Qur hernia mesh.

IV. MANUFACTURING INFORMATION

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

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

C. Identify the date of shipping, date of sale, and the person or entity that purchased each of Plaintiff's device(s).

D. Identify all dates and methods of FDA communication associated with any implant which has the same lot number(s) as those used to implant or which were implanted in the Plaintiff.

E. Identify the method and date of sterilization of Plaintiff's device(s).

F. Identify any data collected to ensure that proper sterilization of Plaintiff's device(s) and/or lot number(s) was achieved.

G. Identify each product from the Plaintiff's C-Qur hernia mesh lot number(s) that failed to conform to the manufacturing specifications.

H. Identify each product from Plaintiff's C-Qur hernia mesh lot number(s) that was reported to fail or cause complications in connection with or following implantation.

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. All documents and communications that you consulted, referred to, or identified in responding to items I.-IV. of this DPF.

B. All documents in your possession, custody or control relating in any way to any Plaintiff or any Plaintiff's family member, whether obtained through a third-party or service, or obtained from the internet, social media, chat room, website, or from any computer or electronic source. The timeframe applicable to this request is limited to any such documents obtained or created prior to the filing of Plaintiff's action. Work product is specifically excluded from this request.

C. Every document relating in any way to the C-Qur product(s) implanted in Plaintiff that was provided or could have been provided to the physician who implanted Plaintiff with said product(s), including but not limited to every instruction, warning, brochure, pamphlet, patient information, training material, or any sales, marketing or promotional information. This request is limited to the versions of the various documentation that were in effect as of the date the C-Qur mesh device was implanted in Plaintiff.

D. Every document reflecting or relating to every communication between Defendant and the physician who implanted Plaintiff with the C-Qur product(s) at issue in this civil action, including but not limited to:

i. Every communication relating in any way to (a) publications or articles regarding any C-Qur device published or submitted for publication to a medical or scientific journal by said physician and/or any of his associates (b) publications or articles regarding any C-Qur device that were written or prepared by said physician and/or any of his associates, whether or not such were submitted to a medical or scientific journal, and/or (c) data collected by said physician regarding C-Qur device;

ii. Every communication between the physician and any sales representative or preceptor of Defendant, every complaint or criticism by such physician relating to any C-Qur hernia mesh product(s) sold by Defendant; and

iii. Every communication with any Defendant relating to any injury or complication experienced by any patient of the physician implanted with any of Defendants' hernia mesh product(s).

E. Every document reflecting or relating in any way to any criticism or complaint about the physician who implanted Plaintiff with the C-Qur product(s) at issue in this civil action, including but not limited to his or her patient selection, implantation technique, or patient care. The timeframe applicable to this request is limited to any such documents obtained or created prior to the filing of Plaintiff's action. Work product is specifically excluded from this request.

F. Every document reflecting or relating in any way to any criticism or complaint about every physician who provided any post-implant treatment to Plaintiff relating to the C-Qur product(s) at issue in this civil action, including but not limited to his or her patient care. The timeframe applicable to this request is limited to any such documents obtained or created prior to the filing of Plaintiff's action. Work product is specifically excluded from this request.

[Each] Defendant's Profile Form Certification

I am an authorized agent of Defendant and I hereby certify that the matters stated herein are not the personal knowledge of the undersigned; that the facts stated herein have been assembled by authorized employees and counsel to Defendant and undersigned is informed that the facts stated therein are true. I further certify in my capacity as an authorized agent of Defendant that the responses herein are true and complete to the best of Defendant's knowledge and that based upon a diligent search and analysis of the information available to the Defendant and their counsel, and that the requested documentation has been provided.

_____

_____
Print Name

_____
Title

Date:_____

EXHIBIT E

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW HAMPSHIRE

IN RE:	)	**MDL NO. 2753**
ATRIUM MEDICAL CORP. C-QUR MESH PRODUCTS LIABILITY LITIGATION	)	**MDL Docket No. 1:16-md-02753-LM**
	)	**ALL CASES**

[EACH] DEFENDANT'S FACT SHEET

For each case, defendants must separately complete this Fact Sheet. Except as otherwise set forth in any Order, this Fact Sheet must be completed and served on plaintiffs' counsel in each individual case within ninety (90) days after Defendants' receipt of Plaintiffs' Fact Sheet in each individual case.

Items within the Defendant Fact Sheet have not been agreed to by the Defendants. Accordingly, the parties have agreed that the Defendants have not waived and in fact have reserved their right to object to the questions in the Defendant Fact Sheet. Defendants may interpose objections, where appropriate, to any particular question or request for documents. However, Defendants have agreed not to assert any objection to the Defendant Fact Sheet on the grounds of numerosity. All objections must comply with the applicable Federal Rules of Civil Procedure.

I. CASE INFORMATION

This defendant fact sheet pertains to the following case:
Case Name:

II. CONTACTS WITH TREATING AND EVALUATING PHYSICIANS

Plaintiff has identified each physician who treated and/or evaluated plaintiff for hernia repair and/or associated conditions that led to the use of defendants' 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 drug or 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 nature of the contact with and 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. Set forth the number of procedures performed by the physician, products used, and the results of those procedures, to the extent known to defendants.

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 or any other person or entity 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 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. The product(s) that the sales representative marketed, sampled, provided to, or otherwise presented to or discussed with the physician.

6. Identify all sales and marketing literature or other information utilized or referenced by the sales representative with regard to the product(s).

7. Set forth the details of all training and instruction provided to the sales representative with regard to the sale and marketing of the defendants' product(s).

8. Set forth all information provided by the sales representative to the physician with regard to the safety, use, or efficacy of the defendants' products.

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

10. Set forth all information provided by the physician to the sales representative, with regard to the plaintiff.

11. Set forth the date, and location of each operation or procedure performed on the plaintiff, which was attended at all by the sales representative.

12. State whether the sales representative 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 defendant's possession or control or which have been reviewed or analyzed by defendant, 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.

B. Identify any direct or indirect contact, either written or oral, between the plaintiff and any employee or representative of the defendant, including but not limited to pre-operative inquiries, and post-operative complaints.

C. Set forth the date, and location of each operation or procedure performed on the plaintiff, which was attended at all by any employee, agent, or contractor of any defendant, and identify the name and position of each person who attended.

D. 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.

E. Identify all written information with regard to the defendant's product(s) that were used to implant and/or implanted into the plaintiff, which were provided to the plaintiff and/or her physician, before the implantation of the defendants' product(s).

F. Identify all written information with regard to the defendant's product(s) that were used to implant and/or implanted into the plaintiff that were available to be provided but were not provided to the plaintiff and/or her physician.

G. Identify all marketing and advertising information that was publicly available or disseminated with regard to the defendant's product(s) that were used to implant and/or implanted into the plaintiff, on and before the date of implantation.

H. If you contend 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:

i) Identify the Alternate Cause with specificity.

ii) Set forth the date and mechanism of Alternate Causation.

iii) Provide any and all factual, legal, expert, or other opinions that support the Alternative Cause.

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).

F. Identify all dates and methods of FDA communication associated with any implant or surgical device which has the same lot number(s) as those used to implant or which were implanted in the plaintiff.

G. Identify the method and date of sterilization of plaintiff's device(s), including but not limited to all other surgical devices or means of implantation included or sold with plaintiff's implant(s).

H. Identify any data collected to ensure that proper sterilization of plaintiff's device(s) and/or lot number(s) was achieved.

I. Identify all means of measuring and determining how plaintiff's lot number was (1) tracked for quality control purposes, and (2) scrapped, at every stage of manufacturing and prior to its being shipped.

J. Identify and include all scrap or other waste percentages associated with each of the following stages (or the equivalent) of manufacturing plaintiff's lot number:

i. Pore size creation and/or measurement;
ii. Elasticity testing;
iii. Implant material integrity;
iv. Filament Structure creation and/or measurement;
v. Weave design implementation;
vi. Overall integrity or the like; and
vii. Use of Omega-3 Fatty Acids.

K. Identify each product from the plaintiff's lot number(s) that failed to conform to the manufacturing specifications.

L. Identify each product from plaintiff's lot number(s) that was reported to fail or cause complications in connection with or following implantation.

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. Identify and attach all records, documents, and information that refers or relates to the plaintiff in defendants' possession or control, to the extent not identified and attached in response to a prior question.

C. Identify and attach any documents to or from plaintiff's physicians with regard to plaintiff and/or the product(s), to the extent not identified and attached in response to a prior question.

D. Identify and attach any research or patient studies that were conducted using any lot number associated with any product used to implant and/or that was implanted into the plaintiff.

[Each] Defendant's Fact Sheet Certification

I am an authorized agent of Defendant and I hereby certify that the matters stated herein are not the personal knowledge of the undersigned; that the facts stated herein have been assembled by authorized employees and counsel to Defendant and undersigned is informed that the facts stated therein are true. I further certify in my capacity as an authorized agent of Defendant that the responses herein are true and complete to the best of Defendant's knowledge and that based upon a diligent search and analysis of the information available to the Defendant and their counsel, and that the requested documentation has been provided.

_____

_____

Print Name

_____

Title

Date:_____

AMENDED*

EXHIBIT F

*Amended 10/16/19

IT I UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW HAMPSHIRE

In Re: Atrium Medical Corp. C-Qur Mesh
Products Liability Litigation (MDL No. 2753)

MDL Docket No. 16-md-2753-LM
ALL CASES

AMENDED JOINT RECORDS COLLECTION AGREEMENT

IT IS HEREBY STIPULATED AND AGREED between the parties as follows:

1. The parties to this litigation hereby agree to jointly use Litigation Management, Inc. ("LMI") to collect for the parties jointly the medical and other records from third parties in this action. Plaintiff(s) agree to provide the agreed-upon releases to LMI, and any party may request that LMI obtain records from a custodian by so advising LMI. Once records are obtained, LMI shall then make such records available to all parties on an equal basis (including the use of the same pricing for all parties), which shall satisfy any obligation of a party obtaining records through LMI to make such records available to other parties. To the extent any provider requires a release other than the agreed-upon release, the Plaintiffs are required to complete the provider-specific authorization form within a reasonable amount of time. All communications with LMI regarding cases in this litigation shall copy liaison counsel for the opposing party.

2. The parties have agreed that the Plaintiffs shall have a period of ten days to review medical records for privilege and withhold production before Defendants shall have access to the records. The full terms of this "quick peek" are described in Case Management Order No. 3G(1)(e).

3. The parties agree that 50% of the total shared costs associated with records collection from each medical provider (or other custodian) will be paid by the Plaintiffs and the other 50% by the Defendants. The scope and cost of services that will be shared by the parties are set forth in Exhibit G. Each party is free to request any of the ancillary services offered by LMI at its own expense.

4. The parties agree that under Federal Rule of Evidence 902(h), document custodians will complete an agreed-upon certificate of acknowledgment which will serve as evidence of authenticity and satisfy the requirements of authentication necessary to admit the records into evidence in this action. Any other evidentiary objections are reserved.

5. Any party may choose to discontinue the use of the joint vendor, LMI, at any time upon thirty (30) days notice to the other party(ies). The withdrawing party will remain responsible for the costs of any records ordered prior to the withdrawal. If a party provides notice of discontinuing the use of the joint vendor, Plaintiffs shall have twenty (20) days from the date of the notice to provide to Defendants the agreed upon releases executed by each Plaintiff. These releases should specifically authorize Dechert LLP c/o Katherine Armstrong at Three Bryant Park, 1095 Avenue of the Americas, New York, NY, 10036-6797 and/or Katherine Unger Davis at Cira Centre, 2929 Arch Street, Philadelphia, PA 19355 to receive the requested information.

6. Each party reserves the right to issue subpoenas or seek commissions and/or employ other discovery requests if necessary or appropriate in order to obtain records.

Respectfully submitted,

SO ORDERED:

_____

LANDYA MCCAFFERTY
UNITED STATES DISTRICT JUDGE

EXHIBIT G

Litigation Management, Inc.
6000 Parkland Boulevard
Mayfield Heights, Ohio 44124
1 800 778 5424
http://www.lmiweb.com

Standard Record Acquisition Services Fees

Service	Fee
Record Collection 1. Standard Request Fee 2. Subpoena Fee (as needed, in place of Request Fee) 3. Receipt Fee 4. Imaging/Bates Stamp/OCR Fee	 1. $40 per request 2. $50 per subpoena, plus any court fees 3. $5 per document received 4. $0.08 per page

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