Notice to DCC Date: 9/4/92

BREAST IMPLANT REMOVAL ASSISTANCE PROGRAM APPLICATION

Report Made By: [redacted]

Address: [redacted]

Phone: [redacted]

Patient's Name: [illegible]

Address:

Phone:

Doctor's Name: ~~D~~ Blayne ~~[illegible]~~ Yurick

Address: 1055 North 200 West Provo, Ut 84604

Phone: 801-375-4[illegible]

Hospital (if any):

Product: S.C.

Size: 350 CC

Cat. No.: P-150-25

Lot No.: HH 126551

Date of Original Surgery: 1/87

Date of Re-Op/Occurrence: 10/5/92

Description of Event: Extracted [illegible] and things on side of implant

Device Return Requested: ____Yes ____No

Why? Testing

Claim Report Made: ____Yes To: _____ Date: _____

____No Why: _____

Comments:

DCC-050242294

Only fill in what you know

Notice to DCW Date: _____

TO WSB: date

Attorney Work Product

CLAIM REPORT FORM

Report Made By: Who is reporting this to us — Dr, pt, spouse, attny

Address: _____

Phone: _____

Patient's Name: _____

Address: _____

Phone: _____

Doctor's Name: _____

Address: _____

Phone: _____

Hospital (if any): _____

Product: D.i. / gel MP

Size: _____

Cat. No: _____

Lot No: _____

Date of Original Surgery _____

Date of Re-Op/Occurrence _____

Description of Event: NO ABSOLUTES — What is the person telling you happened —
the pt. says... Drs. opinion is that...
the pt. alleges... Dr. alleges...
Do not state facts here!!

Device Return Requested: ____ Yes ____ No always ask for product back. Not if obvious it is gone - write down reason

Why? _____

Claim Report Made: ____ Yes; To: ... ~~Complaint Coordinator~~ Date: T Must be within 5 days WSB date

CODE FOR MDRs

____ No; Why: _____

Comments: T there are only 1 or 2 things we don't complain - ~~[illegible]~~ not our product ~~[illegible]~~

Will help legal dept. evaluate as we what they want P/S

Pt. appears to be ... angry — Confused

DCW-0112