DOW CORNING LITIGATION FACILITY
NOTICE OF INTENT TO LITIGATE
CLAIMANT QUESTIONNAIRE

Section I – Court Information

PLACE LABEL HERE

LABEL TO INCLUDE COURT ID

(to be filled in by Litigation Facility)

1. Court Identification _____ *(to be filled in by Litigation Facility only)*
claim specific #

2. Updates /Corrections:

Name _____
Last Name *First Name* *M.I*

Address: _____

3. Other names by which you have been known
(such as maiden name or married names)

Name	Years when name used
_____	_____ to _____
_____	_____ to _____
_____	_____ to _____

☐ Check if never known by any other name
☐ Check if additional names, not listed here
(please provide names on separate sheet)

4. Prior case information (if any)

State Court Name	State Court Number	Federal Court Name	Case Number	Bankruptcy Proof of Claim Number
_____	_____	_____	_____	_____
_____	_____	_____	_____	

Section II - Attorney/Claimant Contact Information

Claimant's attorney, if any. (You do not need an attorney to file this form.)

1. Law firm name: _____ 2. Name of attorney: _____

3. Address: _____ 4. Telephone: (____) _____-_____
_____ Fax: (____) _____-_____
Email: _____

5. Name of Federal Court(s) admitted to practice _____

VERIFICATION

In accordance with 28 U.S.C. §1746, I, the undersigned, declare, under penalty of perjury, that the responses in this questionnaire are true and correct.

Executed on: ___ / ___ / ____
MM DD YYYY

_____
Plaintiff's signature

_____
(Type or legibly print name as signed above)

PLEASE RETURN COMPLETED QUESTIONNAIRE TO:

DCC LITIGATION FACILITY, INC.
P.O. Box 2089
Midland, MI 48641-2089

To be timely, this form MUST be postmarked no later than February 28, 2005.

Section IIA – Prior Questionnaire/Interrogatories

1. Did you complete and submit a claimant questionnaire in the MDL 926 breast implant litigation or answer equivalent state court interrogatories in the breast implant litigation? □ Yes □ No

If you answered "no," please skip this section and proceed to Section III.

If you answered "yes," then you must complete the following Sections of this questionnaire:
(please check the box next to the Section as you complete each section)

- □ Section I
- □ Section II
- □ Section III
- □ Section VII, Questions 3-5
- □ Section VIII.B, Questions 1, 2, and 4
- □ Section XI, Question 3
- □ Section XII, Question 2
- □ Section XV (to the extent different from your prior questionnaire or interrogatory responses)
- □ Section XVI, if applicable
- □ Release A
- □ Release B

You may rely on your answers in the MDL 926 questionnaire or equivalent state court interrogatories for all other sections provided that the answers are complete and current.

If your answers in the MDL 926 questionnaire or equivalent state court interrogatories are not current and complete, you must complete this questionnaire.

2. Are you relying on your MDL 926 questionnaire or equivalent state court interrogatories? □ Yes □ No

If you answered "yes," please sign the verification below.

VERIFICATION

In accordance with 28 U.S.C. §1746, I, the undersigned, declare, under penalty of perjury, that the responses in the attached MDL 926 questionnaire or equivalent state court interrogatories are true and correct as of today's date.

_____ ____/____/_____
Signature of Claimant MM DD YYYY

If you are relying on the MDL 926 questionnaire or equivalent state court interrogatories, you must attach the document(s) to this form.

Section III – Basic Claim Information

1. Does your claim relate to silicone breast implants? □ Yes □ No
If "yes," please answer questions 2-5. If "no," skip to question 6 below.

2. Are you:
□ A breast implant recipient
□ A representative of the estate of a breast implant recipient (please attach order appointing you as Personal Representative or executor)
□ Other. Explain _____

2A. Are you asserting a claim for loss of consortium?
□ Yes □ No

(Note: This questionnaire uses the term "your" to refer to the implant recipient in all questions about medical and employment histories.)

3. Manufacturer of your breast implant(s) for which you are making a claim (check all that apply.) (A list of manufacturer brand names and manufacturers appears in the Claimant Information Guides previously sent by the Settlement Facility-Dow Corning Trust at Tab 1):

□ Dow Corning □ Baxter
□ Bristol-Myers □ Heyer-Schulte
□ 3M □ McGhan
□ CUI □ Mentor
□ Other (specify) _____

4. If Dow Corning did not manufacture all of your breast implants, do you intend to assert a claim alleging that Dow Corning supplied raw materials for the non-Dow Corning implants? □ Yes □ No

5. Are you asserting a claim against any other person or entity relating to your breast implants? □ Yes □ No
If "yes," please identify that person or entity _____

If your claim relates solely to breast implants, skip Question 6 and go to Question 7.

If your claim does **not** relate to breast implants or is not a personal injury claim, please complete Question 6.

6A. If you answered "no" to Question 1 above, does your claim relate to a medical device, implant, or material manufactured by Dow Corning other than silicone breast implants? □ Yes □ No

If you answered "yes" to Question 6A, please complete Sections IV-VII and Sections IX-XVI.

6B. If you answered "no" to Question 6A, briefly describe the nature of your claim:
_____
_____
_____

If your claim is not a personal injury claim, please complete Sections I, II, III, IV, XI, and XII of this form.

7A. Are you making a claim your breast implant(s) caused a disease or illness, including any symptoms? □ Yes □ No

7B. If you answered "yes" to Question 7A above, for each disease, illness or symptom, please provide the following information:

a. Disease/Illness/Symptom _____

Date of Onset ___/___/_____ (MM DD YYYY) Date of Diagnosis___/___/_____ (MM DD YYYY) Duration _____
Did a doctor issue a diagnosis? □ Yes □ No What is the diagnosis? _____

Diagnosing Physician _____ Treating Physician _____

Board Certification of Diagnosing Physician _____

b. Disease/Illness/Symptom _____

Date of Onset ___/___/_____ (MM DD YYYY) Date of Diagnosis___/___/_____ (MM DD YYYY) Duration _____
Did a doctor issue a diagnosis? □ Yes □ No What is the diagnosis? _____

Diagnosing Physician _____ Treating Physician _____

Board Certification of Diagnosing Physician _____

c. Disease/Illness/Symptom _____

Date of Onset ___/___/_____ (MM DD YYYY) Date of Diagnosis___/___/_____ (MM DD YYYY) Duration _____
Did a doctor issue a diagnosis? □ Yes □ No What is the diagnosis? _____

Diagnosing Physician _____ Treating Physician _____

Board Certification of Diagnosing Physician _____

d. Disease/Illness/Symptom _____

Date of Onset ___/___/_____ (MM DD YYYY) Date of Diagnosis___/___/_____ (MM DD YYYY) Duration _____
Did a doctor issue a diagnosis? □ Yes □ No What is the diagnosis? _____

Diagnosing Physician _____ Treating Physician _____

Board Certification of Diagnosing Physician _____

e. Disease/Illness/Symptom _____

Date of Onset ___/___/_____ (MM DD YYYY) Date of Diagnosis___/___/_____ (MM DD YYYY) Duration _____
Did a doctor issue a diagnosis? □ Yes □ No What is the diagnosis? _____

Diagnosing Physician _____ Treating Physician _____

Board Certification of Diagnosing Physician _____

□ Please check if the above subsections do not provide enough space to answer Question 7B fully.
(Provide the additional responses to Question 7B on a separate sheet.)

8A. Whether or not you answered "yes" to Question 7A, are you making a claim that your silicone implant(s) caused any health condition or other injury, other than any disease, illness or symptom set forth in your answer to Question 7 and other than rupture? (Please include any physical disfigurement, if any) □ Yes □ No

8B. If you answered "yes" to Question 8A, please describe the claimed health condition or injury below.

a. Health Condition/Injury _____

Date of Onset ___/___/_____ Date of Diagnosis___/___/_____ Duration _____
MM DD YYYY MM DD YYYY
Did a doctor issue a diagnosis? □ Yes □ No What is the diagnosis? _____

Diagnosing Physician _____ Treating Physician _____

Board Certification of Diagnosing Physician _____

b. Health Condition/ Injury _____

Date of Onset ___/___/_____ Date of Diagnosis___/___/_____ Duration _____
MM DD YYYY MM DD YYYY
Did a doctor issue a diagnosis? □ Yes □ No What is the diagnosis? _____

Diagnosing Physician _____ Treating Physician _____

Board Certification of Diagnosing Physician _____

c. Health Condition/ Injury _____

Date of Onset ___/___/_____ Date of Diagnosis___/___/_____ Duration _____
MM DD YYYY MM DD YYYY
Did a doctor issue a diagnosis? □ Yes □ No What is the diagnosis? _____

Diagnosing Physician _____ Treating Physician _____

Board Certification of Diagnosing Physician _____

□ Please check if the above subsections do not provide enough space to answer Question 8B fully.
(Provide the additional responses to Question 8B on a separate sheet.)

9. Are you making a claim for rupture of your breast implant(s)? □ Yes □ No

10. The answers to Questions 10A and 10B will not be deemed and cannot be used as an admission against the claimant's interest:

A. Have you submitted your proof of manufacturer information to the Settlement Facility – Dow Corning Trust and received back a determination that the proof of manufacturer was unacceptable? □ Yes □ No

B. If you answered "no" to Question 10A, did you refrain from filing a claim with the Settlement Facility because you were concerned that the Settlement Facility would find that your proof of manufacturer evidence was unacceptable?
□ Yes □ No

11. For any disease/illness, health condition, symptom/finding or other injury listed in response to Questions 7B and 8B, has any doctor or health care professional told you that he or she did not believe such disease/illness or symptom/finding was caused by, or related to, your breast implants? □ Yes □ No

Disease/Illness/Health Condition/Symptom/Finding/Injury # (from Questions 7B, 8B)	**Provider Name**	**Provider Address (street, city, state, zip)**

□ Please check if the chart above does not provide enough space to answer Question 11 fully.
(Provide the additional responses to Question 11 on a separate sheet.)

12. For any disease/illness, health condition, symptom/finding or other injury listed in response to Questions 7B and 8B, has any medical professional or healthcare professional told you that he or she did believe such disease/illness or symptom/finding was caused by your breast implants? □ Yes □ No
If you answered "yes" to Question 12, please provide the following information:

Disease/Illness/Health Condition/Symptom/Finding/Injury # (from Questions 7B, 8B)	**Provider Name**	**Provider Address (street, city state, zip)**

□ Please check if the chart above does not provide enough space to answer Question 12 fully.
(Provide the additional responses to Question 12 on a separate sheet.)

Section IV - Personal

1. Date of birth of implant recipient ___ /___ / _____ 2. Place of birth of implant recipient_____
MM DD YYYY (city / state country)

3A. Claimant is:
- ☐ U.S. Citizen or resident
- ☐ Citizen or resident of a foreign country (specify which: _____)

3B. Claimant's Social Security No. _____ - _____ - _____

3C. Claimant's National ID # (if non-U.S.) _____

4A. Current address (Street address; Not P.O. Box)

_____
street / apartment city state zip(or postal code)

country (If not U.S.)_____

4B. Years at current address
_____

4C. Persons who have lived with claimant at current address

Name	Relationship to you	Years when lived with you
_____	_____	_____ (YYYY) to _____ (YYYY)
_____	_____	_____ (YYYY) to _____ (YYYY)
_____	_____	_____ (YYYY) to _____ (YYYY)
_____	_____	_____ (YYYY) to _____ (YYYY)

☐ Check if additional persons, not listed above. **(Provide names, years and relationship on separate sheet.)**

5. All prior addresses, starting 10 years before first breast implant surgery

Street / Apartment	City	State	Country	Zip	Years living at address
_____	_____	_____	_____	_____	From ____ (YYYY) to _____ (YYYY)
_____	_____	_____	_____	_____	From ____ (YYYY) to _____ (YYYY)
_____	_____	_____	_____	_____	From ____ (YYYY) to _____ (YYYY)
_____	_____	_____	_____	_____	From ____ (YYYY) to _____ (YYYY)
_____	_____	_____	_____	_____	From ____ (YYYY) to _____ (YYYY)
_____	_____	_____	_____	_____	From ____ (YYYY) to _____ (YYYY)

☐ Please check if the lines above do not provide enough space to answer Question 5 fully.
(Provide additional responses to Question 5 on a separate sheet.)

6. Marriages (list each marriage)

Name of Spouse	Date of Marriage	Date Marriage Ended	How Marriage Ended (such as divorce, death)
_____	___ / ___ / _____ MM DD YYYY	___ / ___ / _____ MM DD YYYY	_____
_____	___ / ___ / _____ MM DD YYYY	___ / ___ / _____ MM DD YYYY	_____
_____	___ / ___ / _____ MM DD YYYY	___ / ___ / _____ MM DD YYYY	_____

☐ Check if never married

☐ Please check if the lines above do not provide enough space to answer Question 6 fully.
(Provide the additional responses to Question 6 on a separate sheet.)

7. Names of Children and Dates of Birth

Name	Date of Birth
_____	___ / ___ / _____ MM DD YYYY
_____	___ / ___ / _____ MM DD YYYY
_____	___ / ___ / _____ MM DD YYYY
_____	___ / ___ / _____ MM DD YYYY
_____	___ / ___ / _____ MM DD YYYY

☐ Please check if the lines above do not provide enough space to answer Question 7 fully.
(Provide the additional responses to Question 7 on a separate sheet.)

Section V - Education

1. Please provide the following information regarding your educational background:

High School	Address (Street, City, State, Zip)	Grades Completed	Year Graduated

2. If you did not finish high school, do you have a GED? □ Yes □ No

3. Did you attend school beyond high school? □ Yes □ No

If you answered 'yes" to Question 3, please provide the following information for each school you attended:
(Your answer should include any college, vocational, technical or professional school.)

School #1

Name of school	Address (street, city, state, zip)	Dates of attendance From ___/___/____ MM DD YYYY Until ___/___/____ MM DD YYYY	Degree awarded	Field of study

School #2

Name of school	Address (street, city, state, zip)	Dates of attendance From ___/___/____ MM DD YYYY Until ___/___/____ MM DD YYYY	Degree awarded	Field of study

□ Please check if the chart above does not provide enough space to answer Question 3 fully.
(Provide the additional responses to Question 3 on a separate sheet.)

Section VI - Employment History

1. Current Employment: If you are currently employed, provide the following information (your answer should include self-employment):

Employer name	Job title
Address (street, city, state, zip)	Date employed ___ / ___ / _____ MM DD YYYY
Description of duties	Hours per week
	Supervisor's name
	☐ Check if you have more than one current employer **(Provide other current employer info on separate sheet.)**

2. Prior Employment: For the 10-year period before your first breast implant surgery to the present, list all the places you worked other than your current employer(s) or prior to terminating work. Answer the following as to each (your answers should include self-employment):

JOB #1: Employer name	Job title
Address (street, city, state, zip)	Dates employed ___ / ___ / _____ to ___ / ___ / _____ MM DD YYYY MM DD YYYY
Description of duties	Hours per week
Reason(s) For leaving	Supervisor's name

JOB #2: Employer name	Job title
Address (street, city, state, zip)	Dates employed ___ / ___ / _____ to ___ / ___ / _____ MM DD YYYY MM DD YYYY
Description of duties	Hours per week
Reason(s) For leaving	Supervisor's name

JOB #3: Employer name	Job title
Address (street, city, state, zip)	Dates employed ___ / ___ / _____ to ___ / ___ / _____ MM DD YYYY MM DD YYYY
Description of duties	Hours per week
Reason(s) For leaving	Supervisor's name

☐ Please check if the chart above does not provide enough space to answer Question 2 fully.
(Provide the additional responses to Question 2 on a separate sheet.)

Section VII - Health-Related Work Absences

1. Have you ever lost any time from work in excess of 5 consecutive work days due to a sickness, injury or mental condition that you believe was **not** related to your breast implants? (DO **NOT** INCLUDE MATERNITY ABSENCES.)
 □ Yes □ No If "yes," for each period of lost time, please provide the following information:

Employer name	Time lost ___ / ___ / _____ to ___ / ___ / _____ MM DD YYYY MM DD YYYY
Street, city, state, zip	□ Check if you returned to work under any restrictions
Injury or illness causing absence	Describe restriction
□ Please check if the chart above does not provide enough space to answer Question 1 fully. **(Provide the additional responses to Question 1 on a separate sheet.)**	

2. Have you ever applied for worker's compensation, social security or state or federal disability benefits? □ Yes □ No

If you answered "yes" to Question 2, please provide the following information for each application:

Date of application ___ / ___ / ____	Type of benefits
Date benefits started ___ / ___ / ____	Date benefits ended ___ / ___ / _____ MM DD YYYY
Amount awarded	Basis of your claim (Describe the cause and nature of disability)
If denied, reason for denial	
□ Please check if the chart above does not provide enough space to answer Question 2 fully. **(Provide the additional responses to Question 2 on a separate sheet.)**	

3. Has a doctor ever found you to be disabled (include partial, total, and permanent disabilities)? □ Yes □ No

If your answer to Question 3 is "yes," please describe the disability determination below.

Description of Disability	Name/Address of Doctor/Doctor Certification or Specialty	Date Disability Started	Date Disability Ended
		____/____/_____ MM DD YYYY	____/____/_____ MM DD YYYY

4. Has a doctor ever determined that you were disabled as defined by the disability severity/ratings in the MDL breast implant settlement? □ Yes □ No

5. If you answered "yes" to Question 4, what was the doctor's disability/severity determination? _____

Section VIII - Medical History

A. Surgical History:

1. Did you have any surgery on your breasts (including biopsies) before you had breast implants? □ Yes □ No

If you answered "yes" to Question 1, provide the following information for each surgery:

First Surgery:

Surgery date ____ / ____ / _____ MM DD YYYY	
Facility name	Street, city, state, zip
Surgeon name	Street, city, state, zip
Procedure performed	Reason for surgery

Second Surgery:

Surgery date ____ / ____ / _____ MM DD YYYY	
Facility name	Street, city, state, zip
Surgeon name	Street, city, state, zip
Procedure performed	Reason for surgery

Third Surgery:

Surgery date ____ / ____ / _____ MM DD YYYY	
Facility name	Street, city, state, zip
Surgeon name	Street, city, state, zip
Procedure performed	Reason for surgery

□ Please check if the chart above does not provide enough space to answer Question A1 fully.
(Provide the additional responses to Question A1 on a separate sheet.)

B. Breast Implant Surgical History

1. This section relates to breast surgeries from the time you had your first breast implant surgery to the present. Your answer to this question should result in a chronological listing of each breast surgery, regardless of whether breast implants were involved in the surgery.

First Implant(s):

Surgery date ____ / ____ / _____ MM DD YYYY	Reason for surgery
Facility name	Street, city, state, zip
Implanting surgeon name	Street, city, state, zip
The implants were: (Check appropriate box)	
Left Breast (Implant #1) – Use this reference number to identify this specific implant in your responses to questions. □ saline □ gel/saline □ gel filled □ polyurethane covered gel filled □ polyurethane covered gel/saline □ other – specify: _____	Right Breast (Implant #2) – Use this reference number to identify this specific implant in your responses to questions. □ saline □ gel/saline □ gel filled □ polyurethane covered gel filled □ polyurethane covered gel/saline □ other – specify: _____
Brand name	Brand name
Lot #	Lot #
Model or design	Model or design
Catalog #	Catalog #
Manufactured by	Manufactured by
Implant size	Implant size
If you have identified this implant as a Dow Corning product, upon what records or documents do you rely in making this allegation (check all that apply)? Please identify all supporting records and documents below. □ medical records □ operative report(s) □ implant package label □ photographs □ removed implants – describe identifying marks: _____ _____ □ expert examination and report □ doctor's statement □ other – specify: _____ Supporting records/documents: _____ _____ _____	If you have identified this implant as a Dow Corning product, upon what records or documents do you rely in making this allegation (check all that apply)? Please identify all supporting records and documents below. □ medical records □ operative report(s) □ implant package label □ photographs □ removed implants – describe identifying marks: _____ _____ □ expert examination and report □ doctor's statement □ other – specify: _____ Supporting records/documents: _____ _____ _____

IF THE BREAST SURGERIES FOLLOWING YOUR FIRST BREAST IMPLANT SURGERY INVOLVED THE INSERTION OR REMOVAL OF ONLY ONE IMPLANT, PLEASE MAKE THAT CLEAR IN YOUR RESPONSE BY SPECIFICALLY REFERRING TO LEFT OR RIGHT BREAST IMPLANT.

2. Next Surgery:

Surgery date ____ / ____ / _____ MM DD YYYY	Reason for surgery
Facility name	Street, city, state, zip
Surgeon name	Street, city, state, zip

Were the breast implants removed during this surgery? ☐ Yes ☐ No
If "yes," which ones? (Please identify by the sequential number assigned in the previous section.)
Left/Implant #1_____ Right/Implant #2_____

Do you claim that either of these breast implants were ruptured? ☐ Yes ☐ No
If you answered "yes," please identify the ruptured implant: Left/Implant #1 _____ Right/Implant #2 _____

Were either of the breast implants replaced during this surgery? ☐ Yes ☐ No

If either of the breast implants was replaced during this surgery, describe the replacement implant(s) by completing the following sections:

Left Breast (Implant #3)	Right Breast (Implant #4)
☐ saline ☐ gel/saline ☐ gel filled ☐ polyurethane covered gel filled ☐ polyurethane covered gel/saline ☐ other - specify: _____	☐ saline ☐ gel/saline ☐ gel filled ☐ polyurethane covered gel filled ☐ polyurethane covered gel/saline ☐ other - specify: _____
Brand name	Brand name
Lot #	Lot #
Model or design	Model or design
Catalog #	Catalog #
Manufactured by	Manufactured by
Implant size	Implant size

If you have identified this implant as a Dow Corning product, upon what evidence do you rely in making this allegation (check all that apply)? □ medical records □ operative report(s) □ implant package label □ photographs □ removed implants – describe identifying marks: _____ _____ □ expert examination and report □ doctor's statement □ other - specify: _____	If you have identified this implant as a Dow Corning product, upon what evidence do you rely in making this allegation (check all that apply)? □ medical records □ operative report(s) □ implant package label □ photographs □ removed implants – describe identifying marks: _____ _____ □ expert examination and report □ doctor's statement □ other - specify: _____
□ Check if you had more surgeries on your breasts than those listed above. **(Provide information on additional breast surgeries on a separate sheet – number each implant consecutively.)**	

3. a) Did you, your doctor, your attorney, or anyone else to your knowledge retain any of the breast implants that have been removed from your body? □ Yes □ No

b) If you answered "yes" to Question 3(a), please list in chronological order the name and address of each person who has had custody from the time the implant was removed to the present and state whether those persons have inspected or tested the implant, and if so, describe briefly the type or nature of the tests performed, if known.

Implant #1

Name	Address	Tested or Inspected?	Describe type or nature of tests done
1.		□ Yes □ No	
2.		□ Yes □ No	
3.		□ Yes □ No	
4.		□ Yes □ No	
5.		□ Yes □ No	

Implant #2

Name	Address	Tested or Inspected?	Describe Type or Nature of Tests Done
1.		□ Yes □ No	
2.		□ Yes □ No	
3.		□ Yes □ No	
4.		□ Yes □ No	
5.		□ Yes □ No	

□ Check if you have information concerning additional persons or implants not listed above.
(Provide information on additional persons or implants on a separate sheet.)

4. (a) Are you making a claim for ruptured breast implants that have not been removed from your body? □ Yes □ No
If you answered "yes" to Question 4(a), please attach to your questionnaire any medical records or other documents showing that the implants are ruptured.

(b) If you answered "yes" to Question 4(a) above, identify each current implant that you contend is ruptured using the reference number assigned to that implant in Section VIII.B. Questions 1 and 2 of this questionnaire.

Implant #	**Describe Reason for Claiming Rupture**

□ Please check if the chart above does not provide enough space to answer Question 4 fully.
(Provide the additional responses to Question 4 on a separate sheet.)

5. Other than surgery to insert or remove breast implants, have you ever suffered any physical impact or trauma to your breast(s) (such as an accident or fall) or closed capsulotomy procedure any time after receiving your first breast implants?
□ Yes □ No

If your answer is "yes" to Question 5, please provide the following information for each incident:

Date	Implant involved (Use designation # in Section VIII.B.)	Description and effect of event
Witness name(s)		Street, city, state, zip
Did you receive medical treatment? □ Yes □ No		If "yes," please describe treatment:
Treating physician		Street, city, state, zip
Treatment facility		Street, city, state, zip

□ Please check if the chart above does not provide enough space to answer Question 5 fully.
(Provide the additional responses to Question 5 on a separate sheet.)

6. Do you have a family history of any cancer, breast disease, autoimmune disease, or connective tissue disease? ("Family" includes you, your parents, grandparents, aunts, uncles, siblings, and children.) □ Yes □ No
If "yes," then for each condition describe the condition and the relationship to you of each person in the family with the condition.

Condition Name	**Description of the Condition**	**Relation (e.g., aunt, sister, etc.)**

□ Please check if the chart above does not provide enough space to answer Question 6 fully.
(Provide the additional responses to Question 6 on a separate sheet.)

Section IX - Other Hospitalizations or Illnesses

1. To the best of your recollection have you ever been hospitalized for reasons other than the breast implant surgeries described in your previous answers? ☐ Yes ☐ No

If your answer to Question 1 is "yes," please provide the following information with respect to each hospitalization starting with your earliest hospitalization to the present.

Hospitalization No. 1

From ____ / ____ / _____ to ____ / ____ / _____ MM DD YYYY MM DD YYYY	Reason hospitalized
Hospital name	Hospital address (street, city, state, zip)
Treating physician	Physician's address (street, city, state, zip)
Surgery performed? ☐ Yes ☐ No	If "yes," please describe surgery:
☐ Check if more than one treating physician **(Provide information on additional physicians on separate sheet.)**	

Hospitalization No. 2

From ____ / ____ / _____ to ____ / ____ / _____ MM DD YYYY MM DD YYYY	Reason hospitalized
Hospital name	Hospital address (street, city, state, zip)
Treating physician	Physician's address (street, city, state, zip)
Surgery performed? ☐ Yes ☐ No	If "yes," please describe surgery:
☐ Check if more than one treating physician **(Provide information on additional physicians on separate sheet.)**	

☐ Check if you have not listed all hospitalizations responsive to Question 1 above.
(Provide information on additional hospitalizations on a separate sheet.)

2. Have you suffered from any health problems other than the problems you are claiming are related to your breast implants? □ Yes □ No

If you answered "yes" to Question 2 above, please provide the following information for each problem:

Problem #1 description	Problem #2 description
Date of onset ____ / ____ / _____ MM DD YYYY	Date of onset ____ / ____ / _____ MM DD YYYY
Were you treated by a doctor or healthcare professional? □ Yes □ No	Were you treated by a doctor or healthcare professional? □ Yes □ No
If "yes," treating physician's name	If "yes," treating physician's name
Physician's address (street, city, state, zip)	Physician's address (street, city, state, zip)
□ Check if more than one treating doctor. **(Provide information on other doctors on separate sheet.)**	□ Check if more than one treating doctor. **(Provide information on other doctors on separate sheet.)**

□ Check if you have not listed all health problems responsive to Question 2 above.
(Provide information on additional health problems on a separate sheet.)

Section X - Treating Doctors

1. To the best of your recollection, provide the following information for each doctor or healthcare professional who has ever treated you (and that you have not identified in your responses to previous questions). Your answer should include all of your doctors from childhood to the present including, but not limited to, family doctors, obstetricians, gynecologists, osteopaths, chiropractors, physiotherapists, psychiatrists, and psychologists.

Doctor #1

Doctor's name	Doctor's address (street, city, state, zip)
Dates of care From ___ / ___ / _____ to ___ / ___ / _____ MM DD YYYY MM DD YYYY	Reason(s) for care
Type of doctor (i.e., General Practitioner, Internist, etc.)	

Doctor #2

Doctor's name	Doctor's address (street, city, state, zip)
Dates of care From ___ / ___ / _____ to ___ / ___ / _____ MM DD YYYY MM DD YYYY	Reason(s) for care
Type of doctor (i.e., General Practitioner, Internist, etc.)	

Doctor #3

Doctor's name	Doctor's address (street, city, state, zip)
Dates of care From ___ / ___ / _____ to ___ / ___ / _____ MM DD YYYY MM DD YYYY	Reason(s) for care
Type of doctor (i.e., General Practitioner, Internist, etc.)	

☐ Please check if the chart above does not provide enough space to answer Question 1 fully.
(Provide the additional responses to Question 1 on a separate sheet.)

2. Have you ever been denied life insurance coverage? □ Yes □ No

If your answer to Question 2 is "yes," please provide the following information:

Company	Date of Application	Reason for Denial
	___ / ___ / ____ MM DD YYYY	
	___ / ___ / ____ MM DD YYYY	
	___ / ___ / ____ MM DD YYYY	

□ Please check if the chart above does not provide enough space to answer Question 2 fully.
(Provide the additional responses to Question 2 on a separate sheet.)

3. Have you used any prescription drugs or medications (including birth control medications) on a regular basis from the period starting 5 years prior to your first breast implant surgery until the present? ("Regular basis" means something taken consistently for a period in excess of one month.) □ Yes □ No

If you answered "yes" to Question 3, please provide the following information:

Drug Name	Dates Taken	Reason Taken
	From ___ / ___ / ____ to ___ / ___ / ____ MM DD YYYY MM DD YYYY	
	From ___ / ___ / ____ to ___ / ___ / ____ MM DD YYYY MM DD YYYY	
	From ___ / ___ / ____ to ___ / ___ / ____ MM DD YYYY MM DD YYYY	
	From ___ / ___ / ____ to ___ / ___ / ____ MM DD YYYY MM DD YYYY	

□ Please check if the chart above does not provide enough space to answer Question 3 fully.
(Provide the additional responses to Question 3 on a separate sheet.)

Section XI - Economic Damages

1. Claims for Lost Income

Are you claiming loss of income as part of your damages in this lawsuit? □ Yes □ No

If "no," then skip to Question 2 below.
If "yes," please provide the following information for each employer who would have paid the income you are claiming you lost:

Employer #1 name	Employer #2 name
Employer's address (street, city, state, zip)	Employer's address (street, city, state, zip)
Dates missed From ___ / ___ / ____ to ___ / ___ / ____ MM DD YYYY MM DD YYYY	Dates missed From ___ / ___ / ____ to ___ / ___ / ____ MM DD YYYY MM DD YYYY
Lost income	Lostincome
Describe how loss calculated	Describe how loss calculated

□ Please check if the chart above does not provide enough space to answer Question 1 fully.
(Provide the additional responses to Question 1 on a separate sheet.)

2. Claims for Medical Bills

Are you claiming medical bills as damages in this lawsuit? □ Yes □ No

If "yes," what is the total amount that you are claiming? $ _____ *****

*****This information may be supplemented.

(PROVIDE COPIES OF ALL BILLS YOU ARE CLAIMING AS DAMAGES)

3. If you are claiming any other economic damages not listed above, please provide the following:

Detailed Description	Basis for Belief That This Damage Is Related to Your Implant	Amount of Damages
1.		$
2.		$
3.		$

Section XII - Lawsuits and Claims

1. Have you ever brought a lawsuit (other than the lawsuits listed in Section I, Question 4) that involved a claim of personal injury or emotional distress? □ Yes □ No

If you answered "yes" to Question 1, please provide the following information for each lawsuit:

Lawsuit No. 1	**Lawsuit No. 2**
Caption:	Caption:
Court:	Court:
Date filed: ___ / ___ / ____ MM DD YYYY	Date filed: ___ / ___ / ____ MM DD YYYY
Description of lawsuit	Description of lawsuit:
Was lawsuit dismissed? □ Yes □ No Was lawsuit settled? □ Yes □ No	Was lawsuit dismissed? □ Yes □ No Was lawsuit settled? □ Yes □ No

2. Have you ever asserted a claim (other than a formal lawsuit in court) for personal injury or emotional distress? □ Yes □ No

If your answer to Question 2 is "yes," please provide the following information for each claim:

Claim 1	**Claim 2**
Date submitted ____/____/_____ MM DD YYYY	Date submitted ____/____/_____ MM DD YYYY
Person or entity against whom the claim was submitted Name: _____ Title (if an individual): _____	Person or entity against whom the claim was submitted Name: _____ Title (if an individual): _____
Description of claim	Description of claim
Was claim settled? □ Yes □ No	Was claim settled? □ Yes □ No

□ Please check if the charts above do not provide enough space to answer Questions 1 and 2 fully.
(Provide the additional responses to Questions 1 and 2 on a separate sheet.)

Section XIII - Communications with Defendants

1. Have you ever corresponded with any of the parties in this case (including telephone calls, letters, and e-mails)?
   □ Yes □ No

If your answer to Question 1 is "yes," please provide the following information with respect to each communication:

Defendant No. 1	Defendant No. 2
Defendant's name:	Defendant's name:
Defendant's address:	Defendant's address:
Date(s) of communication: ____ / ____ / _____ (MM / DD / YYYY) ____ / ____ / _____ (MM / DD / YYYY)	Date(s) of communication: ____ / ____ / _____ (MM / DD / YYYY) ____ / ____ / _____ (MM / DD / YYYY)
Describe each communication separately (including the name of the person(s) with whom you communicated:	Describe each communication separately (including the name of the person(s) with whom you communicated:

□ Please check if the chart above does not provide enough space to answer Question 1 fully.
(Provide the additional responses to Question 1 on a separate sheet.)

Section XIV - Miscellaneous

1. In addition to the doctors I have already identified in my responses, my attorney, the defendants and any experts retained by my attorney, the following additional persons have knowledge of the facts pertaining to my claim(s) in this lawsuit:

Person #1:
Name: _____ Relationship to you: _____

Address: _____

Description of knowledge: _____

Person #2:
Name: _____ Relationship to you: _____

Address: _____

Description of knowledge: _____

Person #3:
Name: _____ Relationship to you: _____

Address: _____

Description of knowledge: _____

☐ Check if you have not listed all people (with the exception of your attorney, the defendants, treating doctors identified in the responses, and any expert retained by your attorney) with knowledge pertaining to your claim(s) in this lawsuit.
(Provide information on additional people on a separate sheet.)

PLEASE RETURN COMPLETED QUESTIONNAIRE TO:
DCC Litigation Facility, Inc.
P.O. Box 2089
Midland, MI 48641-2089

THIS FORM MUST BE POSTMARKED BY FEBRUARY 28, 2005

Section XV – Documents to Be Attached

(Check the appropriate box)

1. Sign the attached authorization ("Release A") permitting the disclosure of medical records and medical expenses (This release includes both doctors and hospitals.)

   ☐ The executed release is attached.

2. If you are claiming lost wages or jobs as part of your damages in this lawsuit, sign an authorization ("Release B") permitting the disclosure of your employment records for each employer from whom you are claiming lost wages.

   ☐ I am not claiming lost wages, etc.

   ☐ The executed release is attached.

3. All medical records currently in your possession relating to any of your breast implant or explant surgeries.

   ☐ I have no documents responsive to this request.

   ☐ The responsive documents are attached.

   ☐ The responsive documents have been given to my attorney.

4. Those portions of any diaries, journals, logs, or other written materials you have kept which record any of the physical or mental conditions you claim are related to your breast implants.

   ☐ I have no documents responsive to this request.

   ☐ The responsive documents are attached.

   ☐ The responsive documents have been given to my attorney.

5. Any pathology slides or tissue specimens in your possession which relate to your claims in this lawsuit. (If you have forwarded these items to someone for examination, please state where they are located currently and the custodian of the slides or specimens.)

   ☐ I have no items responsive to this request.

   ☐ Items are in the custody of _____

   (name of custodian)

   _____ _____ _____ _____ _____

   (street address) (city) (state) (country) (zip)

6. Any materials you may have received from surgeons, physicians, or other health care professionals who have treated you for any of the conditions that you claim are related to your breast implants. (This would include any consent forms or other materials supplied to you by your implanting physician.)

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

☐ The responsive documents have been given to my attorney.

7. Any literature or materials you may have received (from sources other than your attorney) regarding your breast implants, your breast implant surgeries, or physical conditions you are claiming are related to your breast implants. (This would include, but not be limited to, material provided to you by health care providers, newsletters and materials from support groups, and materials from governmental agencies or medical organizations.)

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

☐ The responsive documents have been given to my attorney.

8. Any materials you may have received from a defendant. (This would include, but not be limited to, any correspondence you may have received if you made a claim to the defendant company prior to bringing your lawsuit as well as product literature or product brochures relating to your breast implants.)

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

☐ The responsive documents have been given to my attorney.

9. Any photographs, videotapes, or other graphic presentation of any of the physical conditions which you are claiming are related to your breast implants. (This would include, but not be limited to, photographs of your breasts both before and after any breast implantation surgery.) These pictures may be held by your attorney subject to need and confidentiality restrictions imposed by the court in this case.

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

☐ The responsive documents have been given to my attorney.

10. Any materials, documents, or correspondence you have generated or gathered which relate to your breast implant surgeries, your breast implants, or any of the physical conditions you are claiming are related to your breast implants. (This includes, but is not limited to, letters you have written to physicians, defendants, government agencies, or support groups. It also includes any research you may have personally undertaken regarding your physical condition.)

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

☐ The responsive documents have been given to my attorney.

11. All claim forms previously submitted in relation to breast implants including, but not limited to, all forms and attachments submitted to the MDL 926 Claims Office and all forms and documents submitted to the Settlement Facility – Dow Corning Trust.

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

☐ The responsive documents have been given to my attorney.

☐ I hereby authorize The DCC Litigation Facility, Inc. to obtain the above-described documents directly from the Settlement Facility-Dow Corning Trust.

_____ ____/_____/_____
Claimant Signature MM DD YYYY

12. All claims and forms submitted to the Social Security Administration, any workers' compensation department or carrier, or any claim submitted to any other disability carrier or provider (including private insurers).

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

☐ The responsive documents have been given to my attorney.

13. Any documents you have which identify the manufacturer of any breast implants you have received. (This would include but not be limited to, any product literature, package inserts, or product brochures regarding your implants.)

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

☐ The responsive documents have been given to my attorney.

14. All medical bills you are claiming as damages in your lawsuit.

☐ I have no documents responsive to this request.

☐ The responsive documents are attached.

☐ The responsive documents have been given to my attorney.

15. Any documents that show any reimbursement you may have received for any of the medical bills you are claiming as damages in your lawsuit.

□ I have no documents responsive to this request.

□ The responsive documents are attached.

□ The responsive documents have been given to my attorney.

16. If you are claiming lost wages, produce your W-2 forms for those years for which you claim a loss and for the 5-year period preceding the year of your first loss.

□ I am not claiming lost wages.

□ The responsive documents are attached.

□ The responsive documents have been given to my attorney.

17. If you are claiming loss of self-employment income, then produce those portions of your tax returns which relate to the loss for each year for which you claim a loss and for the 5-year period preceding the year of your first loss.

□ I am not claiming loss of self-employment income.

□ The responsive documents are attached.

□ The responsive documents have been given to my attorney.

18. If you have received disability benefits in connection with any of the medical conditions alleged in your lawsuit, produce documents which reflect payment of these benefits.

□ I have not received any such benefits.

□ The responsive documents are attached.

□ The responsive documents have been given to my attorney.

19. If you have been the subject of any media coverage regarding breast implants, produce copies of the materials that document this media coverage. If you do not have copies of these materials, describe the media coverage including the date of publication or broadcast.

□ I have not been the subject of any media coverage.

□ The responsive documents are attached.

□ The responsive documents have been given to my attorney.

□ I do not have the responsive materials but I have been the subject of the following media coverage:

_____

_____

PLEASE RETURN COMPLETED QUESTIONNAIRE TO:

DCC Litigation Facility, Inc.
P.O. Box 2089
Midland, MI 48641-2089

Section XVI – Non-Breast Implant Medical Device

(Complete this Section if you are making a claim for a non-breast implant medical device)

1. Please identify the type and manufacturer of the medical device that you claim caused injury. For example, if you were implanted with a large joint orthopedic device, such as a hip joint, please list that under "Device Type."

Device Type	Manufacturer	Date Implanted	Date Removed
		____/____/_____ MM DD YYYY	____/____/_____ MM DD YYYY
		____/____/_____ MM DD YYYY	____/____/_____ MM DD YYYY
		____/____/_____ MM DD YYYY	____/____/_____ MM DD YYYY

2. Are you: □ the medical device recipient □ the representative of the estate of the recipient
□ other - explain: _____

2A. Are you making a claim for loss of consortium? □ Yes □ No

3. Did the medical device contain silicone gel? □ Yes □ No

4. If Dow Corning did not manufacture the medical device, do you claim that Dow Corning supplied the raw material for the device? □ Yes □ No

5. Do you claim that the medical device caused a disease, illness or symptom? □ Yes □ No
If "yes," please answer Question 6. If "no," please go to Question 7.

6. List every disease, illness, or symptom from which you suffer, or have suffered in the past, and which you claim was caused, in whole or in part, by the use of a medical device.

A. Disease/Illness/Symptom _____
Date of Onset ____/____/_____ Date of Diagnosis____/____/_____ Duration _____
MM DD YYYY MM DD YYYY
Did a doctor issue a diagnosis? □ Yes □ No What is the diagnosis? _____
Diagnosing Physician _____ Treating Physician _____
Board Certification of Diagnosing Physician _____

B. B. Disease/Illness/Symptom _____
Date of Onset ____/____/_____ Date of Diagnosis____/____/_____ Duration _____
MM DD YYYY MM DD YYYY
Did a doctor issue a diagnosis? □ Yes □ No What is the diagnosis? _____
Diagnosing Physician _____ Treating Physician _____
Board Certification of Diagnosing Physician _____

C. C. Disease/Illness/Symptom _____
Date of Onset ____/____/_____ Date of Diagnosis____/____/_____ Duration _____
MM DD YYYY MM DD YYYY
Did a doctor issue a diagnosis? □ Yes □ No What is the diagnosis? _____
Diagnosing Physician _____ Treating Physician _____
Board Certification of Diagnosing Physician _____

□ Please check if the subsections above do not provide enough space to answer Question 6 fully.
(Provide the additional responses to Question 6 on a separate sheet.)

7. Whether or not you answered "yes" to Question 6, do you claim that the medical device caused a health

condition or other injury other than or in addition to any disease, illness, or symptom set out in your response to Question 6? □ Yes □ No

If "yes," please answer question 8. If "no," please skip Question 8 and go to Question 9.

8. List every health condition or other injury not included in the response to Question 6 from which you suffer, or have suffered in the past, and which you claim was caused, in whole or in part, by the use of a medical device.

A. Health Condition/Injury _____

Date of Onset ____/____/_____ Date of Diagnosis____/____/_____ Duration _____
MM DD YYYY MM DD YYYY

Did a doctor issue a diagnosis? □ Yes □ No What is the diagnosis? _____

Diagnosing Physician _____ Treating Physician _____

Board Certification of Diagnosing Physician _____

B. Health Condition/Injury _____

Date of Onset ____/____/_____ Date of Diagnosis____/____/_____ Duration _____
MM DD YYYY MM DD YYYY

Did a doctor issue a diagnosis? □ Yes □ No What is the diagnosis? _____

Diagnosing Physician _____ Treating Physician _____

Board Certification of Diagnosing Physician _____

C. Health Condition/Injury _____

Date of Onset ____/____/_____ Date of Diagnosis____/____/_____ Duration _____
MM DD YYYY MM DD YYYY

Did a doctor issue a diagnosis? □ Yes □ No What is the diagnosis? _____

Diagnosing Physician _____ Treating Physician _____

Board Certification of Diagnosing Physician _____

□ Please check if the subsections above do not provide enough space to answer Question 8 fully.
(Provide the additional responses to Question 8 on a separate sheet.)

9. For any disease, illness, or symptom(s) listed in response to Question 6, has any doctor or health care professional told you that he or she did not believe such disease or condition was caused by, or related to, the medical device implants? □ Yes □ No

If your answer to Question 9 is "yes," please provide the following information:

Disease/Illness/Symptom # ***(from Question 6, above)***	**Provider Name**	**Provider Address (street, city, state, zip)**

□ Please check if the chart above does not provide enough space to answer Question 9 fully.
(Provide the additional responses to Question 9 on a separate sheet.)

10. For any health condition or other injury listed in response to Question 8, has any doctor or health care professional told you that he or she did not believe such disease or condition was caused by, or related to, the medical device implants? □ Yes □ No

If you answered "yes" to Question 10, please provide the following information:

Health Condition/Injury ***(from Question 8, above)***	**Provider Name**	**Provider Address (street, city, state, zip)**

□ Please check if the chart above does not provide enough space to answer Question 10 fully.
(Provide the additional responses to Question 10 on a separate sheet.)

11. Do you have a family history of any cancer, autoimmune disease or connective tissue disease? ("Family" includes the recipient, his/her parents, grandparents, aunts, uncles, siblings and children.) □ Yes □ No

If your answer to Question 11 is "yes," then for each condition please describe the condition and the relationship to the recipient of each person in the family with the condition.

Condition Name	**Description of the Condition**	**Relation (i.e., aunt, sister, etc.)**

□ Please check if the chart above does not provide enough space to answer Question 11 fully.
(Provide the additional responses to Question 11 on a separate sheet.)

12. Did you have any surgery (including biopsies) before you received the medical device? □ Yes □ No

If you answered "yes" to Question 12, provide the following information for each surgery:

First Surgery:

Surgery date ____ / ____ / _____ MM DD YYYY	
Facility name	Street, city, state, zip
Surgeon name	Street, city, state, zip
Procedure performed	Reason for surgery

Second Surgery:

Surgery date ____ / ____ / _____ MM DD YYYY	
Facility name	Street, city, state, zip
Surgeon name	Street, city, state, zip
Procedure performed	Reason for surgery

Third Surgery:

Surgery date ____ / ____ / _____ MM DD YYYY	
Facility name	Street, city, state, zip
Surgeon name	Street, city, state, zip
Procedure performed	Reason for surgery

□ Please check if the chart above does not provide enough space to answer Question 12 fully.
(Provide the additional responses to Question 12 on a separate sheet.)

13. This section relates to surgeries from the time you had your first medical device surgery to the present. Your answer to this question should result in a chronological listing of each surgery, regardless of whether the implants were involved in the surgery.

First Medical Device:

Surgery date ____ / ____ / _____ MM DD YYYY	Reason for surgery
Facility name	Street, city, state, zip
Implanting surgeon name	Street, city, state, zip
The implant was: (check appropriate box) ☐ Hip Joint ☐ Knee Joint ☐ Chin ☐ Nose ☐ Testicular ☐ Penile ☐ TMJ ☐ Toe ☐ Wrist ☐ Carpal ☐ Radial ☐ Scapholunate ☐ Trapezial/Trapezium ☐ Ulnar Head ☐ Condylar ☐ Tendon Passer/Spacer ☐ Finger Joint ☐ Other. Specify: _____	Product name Model or design Catalog # / Serial # *(if applicable)* Manufactured by Removal date ____/____/_____ MM DD YYYY

If you have identified this implant as a Dow Corning product, upon what records or documents do you rely in making this allegation (check all that apply). Please identify all supporting records and documents below:

☐ medical records ☐ operative report(s) ☐ device package label(s)
☐ photographs ☐ expert examination and report(s) ☐ doctor's statement
☐ removed device – describe identifying marks _____
☐ other - specify _____

Specific location of device (e.g. left knee, right hip, etc.) _____

Supporting records/documents:
_____
_____

Second Medical Device:

Surgery date ____ / ____ / _____ MM DD YYYY	Reason for surgery
Facility name	Street, city, state, zip
Implanting surgeon name	Street, city, state, zip
The implant was: (check appropriate box) ☐ Hip Joint ☐ Knee Joint ☐ Chin ☐ Nose ☐ Testicular ☐ Penile ☐ TMJ ☐ Toe ☐ Wrist ☐ Carpal ☐ Radial ☐ Scapholunate ☐ Trapezial/Trapezium ☐ Ulnar Head ☐ Condylar ☐ Tendon Passer/Spacer ☐ Finger Joint ☐ Other. Specify: _____	Product name Model or design Catalog # / Serial # *(if applicable)* Manufactured by Removal date ____/____/_____ MM DD YYYY

If you have identified this implant as a Dow Corning product, upon what records or documents do you rely in making this allegation (check all that apply). Please identify all supporting records and documents below:

□ medical records □ operative report(s) □ device package label(s)
□ photographs □ expert examination and report(s) □ doctor's statement
□ removed device – describe identifying marks _____
□ other - specify _____

Specific location of device (e.g. left knee, right hip, etc) _____

Supporting records/documents:
_____
_____

Was the first medical device removed? □ Yes □ No

Third Medical Device:

Surgery date ____ / ____ / _____ MM DD YYYY	Reason for surgery
Facility name	Street, city, state, zip
Implanting surgeon name	Street, city, state, zip
The implant was: (Check appropriate box) □ Hip Joint □ Knee Joint □ Chin □ Nose □ Testicular □ Penile □ TMJ □ Toe □ Wrist □ Carpal □ Radial □ Scapholunate □ Trapezial/Trapezium □ Ulnar Head □ Condylar □ Tendon Passer/Spacer □ Finger Joint □ Other. Specify: _____	Product name Model or design Catalog # / Serial # *(if applicable)* Manufactured by Removal date ____/____/_____ MM DD YYYY

If you have identified this implant as a Dow Corning product, upon what records or documents do you rely in making this allegation (check all that apply). Please identify all supporting records and documents below:

□ medical records □ operative report(s) □ device package label(s)
□ photographs □ expert examination and report(s) □ doctor's statement
□ removed device – describe identifying marks _____
□ other - specify _____

Specific location of device (e.g. left knee, right hip etc) _____

Supporting records/documents:
_____
_____

Was the second medical device removed? □ Yes □ No

14. A) Did you, your doctor, your attorney, or anyone else to your knowledge retain any of medical devices that have been removed from your body? □ Yes □ No

B) If your answer to Question 14A is "yes," list in chronological order the name and address of each person who has had custody from the time the implant was removed to the present and state whether those persons have inspected or tested the implant, and if so, briefly describe the type or nature of the tests performed, if known.

Medical Device #1

Name	Address	Tested or Inspected?	Describe Type or Nature of Tests Done
1.		□ Yes □ No	
2.		□ Yes □ No	
3.		□ Yes □ No	
4.		□ Yes □ No	

Medical Device #2

Name	Address	Tested or Inspected?	Describe Type or Nature of Tests Done
1.		□ Yes □ No	
2.		□ Yes □ No	
3.		□ Yes □ No	
4.		□ Yes □ No	

□ Check if you have information concerning additional persons or implants not listed above.
(Provide information on additional persons or implants on a separate sheet.)

15. Other than surgery to insert or remove a medical device, have you ever suffered any physical impact or trauma after insertion of the medical device? □ Yes □ No

If your answer is "yes" to Question 15, please provide the following information for each incident:

Date ____/____/_____ MM DD YYYY	Device involved (Use designation # in Question 13)	Description and effect of event
Witness name(s)		Street, city, state, zip
Did you receive medical treatment? □ Yes □ No		If "yes," please describe treatment:
Treating physician		Street, city, state, zip
Treatment facility		Street, city, state, zip

□ Please check if the chart above does not provide enough space to answer Question 15 fully.
(Provide the additional responses to Question 15 on a separate sheet.)

RELEASE A

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information ("PHI") as described below for the purpose of review and evaluation in connection with a legal claim. I expressly request that all entities covered under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") identified below disclose full and complete PHI spanning the time period of my date of birth to the present, including the following: all medical records, correspondence, laboratory reports, notes, radiology films, pharmacy/prescription records, billing records, and insurance records. This authorization is effective only to the extent allowed under the applicable state law.

(Check one) ☐ This release specifically does not authorize you to release any records pertaining to any mental health, psychiatric, or psychological treatment without further express consent from me. DCC Litigation Facility, Inc. reserves the right to seek these additional records in the future.

☐ This release specifically does authorize you to release any records pertaining to any mental health, psychiatric, or psychological treatment without further express consent from me.

Patient Name: _____

Patient SSN: _____ Patient Date of Birth: _____/_____/_____
MM DD YYYY

I authorize you to release the PHI to any employee, agent or lawyer of The DCC Litigation Facility, Inc. This authorization is limited to the release of PHI; it specifically does not authorize any persons/organizations authorized to make disclosures to discuss my PHI, medical care or treatment with any employee, agent or lawyer of The DCC Litigation Facility, Inc.

Persons/Organizations Authorized to Make the Requested Disclosures

- I understand that I have the right to revoke this authorization at any time by writing to The DCC Litigation Facility, Inc. and/or my health care providers listed above. I understand, however, that actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- I understand that this authorization is voluntary and that once this information has been disclosed it may be subject to re-disclosure and would no longer be protected by federal privacy regulations.
- I understand that the health care providers to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign this authorization.
- Any facsimile or photocopy of this authorization shall authorize you to release the records described herein.

Signature: _____ Date: _____/_____/_____
MM DD YYYY

If the Authorization is signed by a Personal Representative of the Individual, a description of such representative's authority to act for the individual:

_____

RELEASE B

AUTHORIZATION FROM EMPLOYEE TO RELEASE EMPLOYMENT INFORMATION

Employee Name: _____

Employee SSN: _____ Employee Date of Birth: _____/_____/_____
MM DD YYYY

Persons/Organizations Authorized to Make the Requested Disclosures

The above-named employer(s) is(are) hereby authorized to copy or make available for inspection and copying, for the attorneys requesting this information or their representatives presenting the original or photostatic copy hereof, documents relevant to dates of my employment, my absences, my reasons for termination or leaving, my evaluations, my wages or salary, my illnesses and injuries. This release does not authorize any persons/organization authorized to make disclosures to discuss my employment with any employee, agent, or lawyer of The DCC Litigation Facility, Inc.

This release specifically does not authorize you to release any records pertaining to any mental health, psychiatric, or psychological treatment without further express authorization from me.

- I understand that I have the right to revoke this authorization at any time by writing to The DCC Litigation Facility, Inc. and/or my health care provider(s) listed above. I understand, however, that actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

- Any facsimile or photocopy of this authorization shall authorize you to release the records described herein.

Signature: _____ Date: _____/_____/_____
MM DD YYYY

If the Authorization is signed by a Personal Representative of the Individual, a description of such representative's authority to act for the individual:

_____