IN RE: PROPECIA® LITIGATION APPLICABLE TO ALL CASES	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: MIDDLESEX COUNTY CASE NO. 623 CIVIL ACTION Case Management Order No. 3 (Plaintiff Fact Sheet)

1. Each plaintiff in an action currently pending before the Court in Case No. 623 shall complete and serve upon Defendants via email to NJ623PFS@butlersnow.com or by certified mail to:

   Aaron R. Rice
   Butler Snow LLP
   1020 Highland Colony Parkway, Suite 1400
   Ridgeland, Mississippi 39157

   a ***complete*** "Plaintiff Fact Sheet" (PFS), the form of which has been agreed to by the Parties and approved by the Court, a copy of which is attached hereto as Exhibit "A", along with responsive documents and authorizations to be completed.

   In addition, each Plaintiff shall send a copy of the PFS and responsive documents to:

   propecianjpfs@thesandersfirm.com

2. For those plaintiffs who are Parties to an action pending before the Court as of the date of entry Case Management Order No. 3 (the "Original Cases"), ***a completed*** PFS shall be served by the following deadlines:

A. No later than fifteen (15) days from the date of entry of this Order, each firm that represents plaintiffs in this litigation shall serve a list of the Original Cases for which it is the originating firm.

B. No later than thirty (30) days from the date of entry of this Order, each originating firm shall have served a completed PFS for one-fourth of the Original Cases for which it is the originating firm.

C. No later than sixty (60) days from the date of entry of this Order, each originating firm shall have served a completed PFS for one-fourth of the remaining Original Cases for which it is the originating firm.

D. No later than ninety (90) days from the date of entry of this Order, each originating firm shall have served a completed PFS for one-fourth of the remaining Original Cases for which it is the originating firm.

E. No later than one hundred and twenty (120) days from the date of entry of this Order, each originating firm shall serve a completed PFS for the remainder of all Original Cases for which it is the originating firm.

3. No later than five (5) days prior to each deadline set forth in Paragraph 2, each originating firm shall serve a list identifying one-fourth of the cases for which it is the originating firm, and for which the subsequent deadline in Paragraph 2 shall apply (***a "Production List"***). At any time prior to the expiration of any deadline set forth in Paragraph 2, any originating firm may serve an Amended Production List in order to substitute cases for which the subsequent deadline in Paragraph 2 shall apply.

4. For those plaintiffs who join Case No. 623 subsequent to the date of entry of this Order, ***a completed*** PFS shall be served no later than one hundred and thirty-five (135) days from the date of filing a complaint in Case No. 623 before this Court.
5. In the event Plaintiffs' counsel are unable to complete production of all outstanding PFSs for the Original Cases within the deadlines set forth above, the Parties shall meet and confer to discuss the option of additional time prior to proceeding with any remedy set forth in Paragraph 8, including but not limited to, additional time to complete the PFSs on the Original Cases.
6. Plaintiffs and their counsel shall use their best efforts to serve the completed PFS on a rolling basis prior to the deadlines set forth above.
7. In the event an institution, agency or medical provider to which a signed authorization is presented refuses to provide responsive documents, the individual Plaintiff's attorney and Defendant's counsel shall meet-and-confer to determine the most efficient way to resolve the issue such that the necessary documents are promptly provided.
8. If a plaintiff fails to comply with this Order in submitting a PFS, Defendants may send a Notice of Overdue Discovery ***(a "Deficiency Letter")*** to Plaintiff's counsel of record ***within thirty (30)*** days after said deadline ***or receipt of the PFS by email and mail. The Deficiency Letter shall permit Plaintiff thirty (30)*** days to cure the ***purported deficiency***. In the event ***a completed*** PFS is not provided within such ***thirty (30)*** day period, Defendants shall exercise all reasonable efforts to meet-and-confer with Plaintiff's counsel ***(for a period of not less than twenty (20) days)***. If, after the meet-and-confer process, the discovery remains overdue ***or allegedly deficient***, Defendants may move to dismiss that plaintiff's case. Said motion to dismiss shall be without prejudice, on Notice to the Court, and permit fourteen (14) days for an opposition, if any. Defendant shall serve ***Randi Kassan*** and ***Vicki Maniatis,*** via e-mail

at propecianjpfs@thesandersfirm.com and the firm representing the Plaintiff in that specific matter, via e-mail a copy of all Notices of Overdue Discovery letters and copies of any and all motions to dismiss.

9. The admissibility of information in the PFS shall be governed by the New Jersey Rules and no objections are waived by virtue of any PFS response.

10. All information contained in the PFS is confidential and protected under the Stipulation and Order Regarding Confidential Information entered in this matter.

11. Within 30 days of the receipt of any records obtained pursuant to an authorization provided with the PFS, the Defendants shall make such records available electronically to the attorney for each individual plaintiff. Lead and/or liaison counsel for the parties shall meet and confer regarding the process for making such records available, including any associated costs, if warranted and applicable.

SO ORDERED:

Dated: October 28th, 2014

JESSICA R. MAYER, J.S.C.

[illegible] OBJECTION TO THE FORM OF JUDGEMENT/ORDER RECEIVED PER R. 4:42-1(c)

AUTHORIZATION AND CONSENT
TO RELEASE PSYCHOTHERAPY NOTES

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

Provider Name:_____

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

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

The Social Security Administration

The 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 **Butler Snow LLP, P. O. Box 6010, Ridgeland, MS 39158,** 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:

  _____

- 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 **Butler Snow LLP, Attention: Butler Snow Privacy Officer, P.O. Box 6010, Ridgeland, Mississippi, 3915,** 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 snbject 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 Butler Snow LLP, pursuant to this authorization will be shared with any and all co-defendants in the matter of _____ 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 _____. **(ii) five (5) years after the date of signature of the undersigned below.**

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to Butler Snow LLP, P. O. Box 6010, Ridgeland, MS 39158, and its authorized representatives, by any entities included in the categories listed above.

Date: _____ _____

Signature of Individual or Individual's Representative

Individual's Name and Address: _____

Printed Name of Individual's Representative (If applicable)

_____ _____

_____ Relationship of Representative to Individual (If applicable)

_____ _____

_____ _____

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

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

Form **4506**

(Rev. September 2013)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Return or Account Transcript" or call 1-800-908-9946.

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

Litigation Management, Inc., 6000 Parkland Boulevard, Mayfield Heights, OH 44124; Phone: (888) 803 - 8706; Fax: (440) 484 - 2055

Caution. *If the tax return is being mailed to a third party, ensure that you have filled in lines 6 and 7 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 return 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 return information, you can specify this limitation in your written agreement with the third party.*

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ 1040

Note. *If the copies must be certified for court or administrative proceedings, check here* . . . . . ☑

7 **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 eight years or periods, you must attach another Form 4506.

12/31/2013	12/31/2012	12/31/2011	12/31/2010
12/31/2009	12/31/2008	12/31/2007	

8	**Fee.** There is a $50 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.**		
a	Cost for each return	$	50.00
b	Number of returns requested on line 7		7
c	Total cost. Multiply line 8a by line 8b	$	350.00
9	If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here		☑

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 return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, partner, 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 on behalf of the taxpayer. **Note.** *For tax returns being sent to a third party, this form must be received within 120 days of the signature date.*

Sign Here	▶ **Signature** (see instructions)	Date	Phone number of taxpayer on line 1a or 2a
	▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)		
	▶ **Spouse's** signature	Date	

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506*. Information about any recent developments affecting Form 4506, Form 4506T and Form 4506T-EZ will be posted on that page.

General Instructions

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

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate (on line 5) a third party to receive the tax return.

How long will it take? It may take up to 75 calendar days for us to process your request.

Tip. Use Form 4506-T, Request for Transcript of Tax Return, to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of non-filing, and records of account.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Return or Account Transcript" or call 1-800-908-9946.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	Internal Revenue Service RAIVS Team Stop 37106 Fresno, CA 93888
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	Internal Revenue Service RAIVS Team Stop 6705 P-6 Kansas City, MO 64999

Chart for all other returns

If you lived in or your business was in:	Mail to:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250

Specific Instructions

Line 1b. Enter your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the address on Lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address. For a business address, file Form 8822-B, Change of Address or Responsible Party — Business.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the return be sent to a third party, the IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. If you request a copy of a tax return, sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

Do not send the form to this address. Instead, see *Where to file* on this page.

LIMITED AUTHORIZATION TO DISCLOSE 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, 6000 Parkland Blvd, Mayfield Hts., OH 44124, as an agent for Butler Snow LLP, P. O. Box 6010, Ridgeland, MS 39158, **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, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
* All 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.

1. To my medical provider: this authorization is being forwarded by, or on behalf of, attorneys for the defendants and has been approved by the Court supervising this litigation. This authorization is for the sole purpose of allowing copies of my medical records to be provided to the defendants in this litigation. It does not allow discussions of my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition.

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 the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire until the later of: (i) the date of settlement or final disposition of _____ *v. Merck & Co., Inc. and Merck Sharp & Dohme Corp*, (ii) five (5) years after the date of signature of the undersigned below.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser 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 _____

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

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

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- You, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

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).*

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:**	***ADDRESS OF PERSON OR ORGANIZATION:**
LITIGATION MANAGEMENT, INC.	6000 PARKLAND BOULEVARD
	MAYFIELD HEIGHTS, OH 44124

***I want this information released because:** to be used in support of an active litigation.

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

Invoices can be sent via fax to: 440-484-2055, please reference the PacketID number found above Social Security Disability on the request letter.

Please feel free to contact Litigation Management, Inc. directly at (888) 803 - 8706 with any questions.

***Please release the following information selected from the list below:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☐ 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 _____ to date PRESENT.
5. ☒ My Medicare entitlement from date _____ to date PRESENT.
6. ☐ Medical records from my claims folder(s) from date_____ to date_____

   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 **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**

   Documents or other items relating to my social security claims(s): applications, questions, petitions, payment documents/decisions/awards/denials, jurisdictional documents/notes, transcripts, correspondence, findings, notice of hearings, hearing records, orders, depositions, reports; witnesses, medical reviewers and experts consultative examination reports, current developments/temporary, non-disability development and documentation, medical records and determination records.

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 any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain 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:** _____

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. 5/12) (Page 1)
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OMB No. 3095-0029 Expires 01/31/2015

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 clearly or type.)

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

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	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 COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
☐ NO ☐ YES _____

7. IS (WAS) THIS PERSON RETIRED 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.** When was the DD Form(s) 214 issued? YEAR(S): _____
If more than one period of service was performed, even in the same branch, there may be more than one DD214.

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.** Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

An undeleted copy will be sent unless you specify a deleted copy. Indicate here if you want a deleted copy of the DD Form 214. ☐

The following items are deleted: 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.

☒ **All Documents in Official Military Personnel File (OMPF)**

☒ **Medical Records** (Includes Service Treatment Records, Health (outpatient) and dental records.) If hospitalized (inpatient), the facility name and date for each admission **must** be provided: _____

☒ **Other** (Specify): Any and all medical records, clinic records, reports, disability claims and benefits

2. PURPOSE: (An explanation of the purpose of the request is **strictly voluntary**; however, such information 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.) Check appropriate box:

☐ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal

☒ Other, explain: In support of active litigation.

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER IS: (*Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.) No signature required for Archival records.*

☐ Military service member or veteran identified in Section I, above
☐ Next of kin of deceased veteran: _____ *(Relationship)*
☐ Legal guardian (Must submit copy of court appointment.)
☐ Other (specify) _____

MUST HAVE PROOF OF DEATH - See item 2a on instruction sheet.

2. 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

3. AUTHORIZATION SIGNATURE WHEN REQUIRED *(See items 2a or 3a on accompanying instructions.)* 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. No signature required for Archival records.

Signature Required - Do not print **Date**

( ) ( )
Daytime phone Fax Number

Email address

*This form is available at *http://www.archives.gov/research/order/standard-form-180.pdf* on the National Archives and Records Administration (NARA) web site.*

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial)
	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Litigation Management Inc, 6000 Parkland Blvd, Mayfield Heights, Ohio 44124

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☒ COPY OF HOSPITAL SUMMARY ☒ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

Any and all records for all dates of service

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Legal

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

Conclusion of Litigation

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY

VA FORM MAY 2005 **10-5345** USE EXISTING STOCK OF VA FORM 10-5345, DATED NOV 2004.

Social Security Administration

Form Approved
OMB No. 0960-0525

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. Certified/Non-Certified Detailed Earnings Information
Includes periods of employment or self-employment and the names and addresses of employers.

OR

2. Certified Yearly Totals of Earnings
Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM TO REQUEST YEARLY EARNINGS TOTALS

Yearly earnings totals are FREE to the public if you do not require certification.

To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Privacy Act Statement
Collection and Use of Personal Information

Section 205 of the Social Security Act, as amended, authorizes us to collect the information on this form. We will use the information you provide to identify your records and send the earnings information you request. Completion of this form is voluntary; however, failure to do so may prevent your request from being processed.

We rarely use the information in your earnings record for any purpose other than for determining your entitlement to Social Security benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

A complete list of routine uses for earnings information is available in our Systems of Records Notices entitled, the Earnings Recording and Self-Employment Income System (60-0059), the Master Beneficiary Record (60-0090), and the SSA-Initiated Personal Earnings and Benefit Estimate Statement (60-0224).
In addition, you may choose to pay for the earnings information you requested with a credit card. 31 C.F.R. Part 206 specifically authorizes us to collect credit card information. The information you provide about your credit card is voluntary. Providing payment information is only necessary if you are making payment by credit card. You do not need to fill out the credit card information if you choose another means of payment (for example, by check or money order). If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and the Social Security Administration's (SSA) account.

Routine uses applicable to credit card information, include but are not limited to:
(1) to enable a third party or an agency to assist Social Security to effect a salary or an administrative offset or to an agent of SSA that is a consumer reporting agency for preparation of a commercial credit report in accordance with 31 U.S.C. §§ 3711, 3717 and 3718; and (2) to a consumer reporting agency or debt collection agent to aid in the collection of outstanding debts to the Federal Government.
A complete list of routine uses for credit card information is available in our System of Records Notice entitled, the Financial Transactions of SSA Accounting and Finance Offices (60-0231). The notice, additional information regarding this form, routine uses of information, and our programs and systems is available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 11 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. Provide your name as it appears on your most recent Social Security card or the name of the individual whose earnings you are requesting.

First Name: Middle Initial:

Last Name:

Social Security Number (SSN) - - One SSN per request

Date of Death: / / Date of Birth: / /

Other Name(s) Used
(Include Maiden Name)

2. What kind of earnings information do you need? (Choose **ONE** of the following types of earnings or SSA must return this request.)

☒ **Itemized Statement of Earnings $102**
(Includes the names and addresses of employers)

If you check this box, tell us why you need this information below.

Active litigation

Year(s) Requested: to
Year(s) Requested: to

☒ Check this box if you want the earnings information **CERTIFIED** for an additional $32.00 fee.

☐ **Certified Yearly Totals of Earnings $32**
(Does not include the names and addresses of employers)
Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Year(s) Requested: to
Year(s) Requested: to

3. If you would like this information **sent to someone else**, please fill in the information below.
I authorize the Social Security Administration to release the earnings information to:

Name Litigation Management Inc

Address 6000 Parkland Boulevard State OH

City Mayfield Heights ZIP Code 44124

4. I am the individual to whom the record pertains (or a person authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

Signature of Individual or legal guardian

SSA must receive this form within 60 days from the date signed

Date: / /

Relationship (if applicable, you must attach proof) Daytime Phone:

Address State

City ZIP Code

Witnesses must sign this form ONLY if the above signature is by marked (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)*

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

INFORMATION ABOUT YOUR REQUEST

You may use this form to request earnings information for **only ONE** Social Security Number (SSN)

How do I get my earnings statement?

You must complete the attached form to tell us the specific years of earnings you want and provide **ONE** mailing address. Mail the completed form to SSA within 60 days of signature. If you sign with an "X", your mark must be witnessed by two impartial persons who must provide their name and address in the spaces provided.
Select **ONE** type of earnings statements and include the appropriate fee.

1. Certified/Non-Certified Itemized Statement of Earnings
This statement includes years of self-employment or employment and the names and addresses of employers.

2. Certified Yearly Totals of Earnings
This statement includes the total earnings for each year requested but *does not* include the names and addresses of employers.

If you require one of each type of earnings statement, you must complete two separate forms. Mail each form to SSA with one form of payment attached to each request.

How do I get someone else's earnings statement?

You may get someone else's earnings information if you meet one of the following criteria, attached the necessary documents to show your entitlement to the earnings information and include the appropriate fee.

1. Someone Else's Earnings
The natural or adoptive parent or legal guardian of a minor child, or the legal guardian of a legally declared incompetent individual, may obtain earnings information if acting in the best interest of the minor child or incompetent individual. You must include proof of your relationship to the individual with your request. The proof may include a birth certificate, court order, adoption decree, or other legally binding document.

2. A Deceased Person's Earnings
You can request earnings information from the record of a deceased person if you are:
- The legal representative of the estate;
- A survivor (that is, the spouse, parent, child, divorced spouse of divorced parent); or
- An individual with a material interest (e.g., financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

You must include proof of death and proof of your relationship to the deceased with your request.

Is There A Fee For Earnings Information?

Yes. We charge a $102 fee for providing information for purposes unrelated to the administration of our programs.

1. Certified or Non-Certified Itemized Statement of Earnings
In most instances, individuals request itemized statements of earnings for purposes unrelated to our programs such as for a private pension plan or personal injury suit. Private pension plans may email OCO.Pension.Fund@ssa.gov for an alternate method of obtaining itemized earnings information.

We will **certify** the itemized earnings information for an additional $32.00 fee. Certification is usually not necessary unless you are specifically requested to obtain a certified earnings record.

Sometimes, there is no charge for itemized earnings information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the year(s) in question. Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

2. Certified Yearly Totals of Earnings
We charge $32 to certify yearly totals of earnings. However, if you do not want or need certification, you may obtain yearly totals *FREE* of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are advised specifically to obtain a certified earnings record.

Method of Payment
DO NOT SEND CASH.

You may pay by credit card, check or money order.
- Credit Card Instructions
  Complete the credit card section on page 4 and return it with your request form.

- Check or Money Order Instructions
  Enclose one check or money order per request form payable to the Social Security Administration and write the Social Security number in the memo.

How long will it take SSA to process my request?

Please allow SSA 120 days to process this request. After 120 days, you may contact 1-800-772-1213 to leave an inquiry regarding your request.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

- **Where do I send my complete request?**

Mail the completed form, supporting documentation, and applicable fee to: **Social Security Administration** Division of Earnings Record Operations P.O. Box 33003 Baltimore, Maryland 21290-3003	If using private contractor such as FedEx mail form, supporting documentation and applicable fee to: **Social Security Administration** Division of Earnings Record Operations 300 N. Greene St. Baltimore, Maryland 21290-0300

- **How much do I have to pay for an Itemized Statement of Earnings?**

Non-Certified Itemized Statement of Earnings	**Certified** Itemized Statement of Earnings
$102.00	$134.00

- **How much do I have to pay for certified yearly totals of earnings?**

Certified yearly totals of earnings cost $32.00. You may obtain non-certified yearly totals *FREE* of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are specifically asked to obtain a certified earnings record.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply. You may also pay by check or money order. Make check payable to Social Security Administration.

CHECK ONE	☐ Visa ☐ American Express ☐ MasterCard ☐ Discover
Credit Card Holder's Name (Enter the name from the credit card)	First Name, Middle Initial, Last Name
Credit Card Holder's Address	Number & Street City, State, & ZIP Code
Daytime Telephone Number	( ) - Area Code
Credit Card Number	- - -
Credit Card Expiration Date	(MM/YY)
Amount Charged See above to select the correct fee for your request. Applicable fees are $32, $102 or $134. SSA will return forms without the appropriate fee.	$
Credit Card Holder's Signature	

DO NOT WRITE IN THIS SPACE **OFFICE USE ONLY**	Authorization Name / Date Remittance Control #

IN RE: PROPECIA® LITIGATION	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: MIDDLESEX COUNTY CASE NO. 623 CIVIL ACTION

PLAINTIFF FACT SHEET

Please provide the following information regarding yourself or each individual on whose behalf a personal injury claim is being made.

Each question must be answered in full. Do not leave any questions unanswered or blank. Each question must be answered, even if you can only answer the question by indicating "none" or "not applicable." Where a question calls for a date or date range, it is sufficient to provide a date range in the following format MO/YEAR through MO/YEAR. If you provide the year but do not provide the month for a requested date or date range, your answer will be considered an affirmative statement that you do not know or cannot recall the month of the requested date or date range.

If you do not know or cannot recall the information needed to answer a question, please indicate that in response to the question. If you affirmatively indicate that you do not know or cannot recall any of the information sought by a question, your answer will not be considered deficient, but you must supplement those responses as soon as the information becomes available to you. By considering such answers sufficient, Merck does not waive its right to seek this information at a later date.

To the extent you cannot completely answer any question, please provide whatever information is available to you and, as to any information sought by the question which you do not know, please identify what part of the question you cannot answer.

Please attach as many sheets of paper as necessary to fully answer these questions.

In filling out this form, please use the following definitions:

1) "**document**" means any writing or record of every type that is in your possession, custody or control or in the possession, custody or control of your counsel, including but not limited to written documents, e-mails, cassettes, videotapes, photographs, charts, computer discs or tapes, x-rays, drawings, graphs, non-

identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into any reasonably usable form.

2) "**health care provider**" or "**health care practitioner**" means any hospital, clinic, center, physician's office, dentist's office infirmary, medical or diagnostic laboratory, or other facility that provides medical, psychiatric, mental, emotional or psychological care or advice, and any doctor, physician, surgeon, oncologist, radiologist, pathologist, natural health provider, homeopath, osteopath, chiropractor, paramedic, nurse (registered or otherwise), physiotherapist, psychiatrist, psychologist, therapist or any other person practicing any healing art, or performing any physical, or radiological, or mental evaluation or examination or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you;

3) "**mental health care provider**" means any psychiatrist, psychologist, therapist or provider of mental health care evaluation, diagnosis and/or treatment. (2)

4) "**Propecia**" means PROPECIA®

5) "**Proscar**" means PROSCAR®.

6) "**Merck**" means Merck & Co., Inc. and/or Merck Sharp and Dohme Corp.

7) "**You**": Other than in Section I(D), those questions using the term "You" should refer to the person who used Propecia and/or Proscar.

You are requested to produce documents (as defined above) in response to questions in this fact sheet or that relate to Propecia and/or Proscar or medications you took, or to the incident, injuries, claims or damages that are the subject of your complaint or, if you have any unused Propecia and/or Proscar and its accompanying packaging, you are requested to produce copies as well.

Whenever you are asked for the name and address of an individual or entity, you are to provide the full name and complete address for that individual or entity to the best of your recollection.

I. CASE INFORMATION

A. Name of person completing this form _____

B. Please state the following for the civil action which you have filed:

1. Case Caption: _____

2. Docket No.: _____

3. Court in which action was originally filed: _____

4. Court in which action is pending now: _____

C. Please state the name, address, and telephone number of the principal attorney representing you:

_____
Name of attorney

_____
Firm name

_____
City, State and Zip Code

_____
Telephone number

D. If you are completing this questionnaire on behalf of someone else (e.g., a deceased person, an incapacitated person), please complete the following:

_____
Your Name

_____
Address

_____
Social Security Number

In what capacity are you representing the individual? _____

_____

If you were appointed by a court, please provide a copy of the order of appointment or power of attorney/authorizing document and state the:

_____
Court Date of Appointment

What is your relationship to the deceased or represented person?

_____

If you represent a decedent's estate, state the date of the decedent's death:

_____

II. CLAIM INFORMATION

A. Do you claim that you have suffered a physical injury as a result of Propecia and/or Proscar use?

Yes _____ No _____

1. **If "yes,"** state the nature of the physical injury or injuries which you claim.

_____

_____

_____

_____

_____

2. When do you claim your symptoms first began? _____

_____

3. When do you claim your date of diagnosis, if any, is:

_____
(month/day/year)

4. Who diagnosed this injury:

Name	Address	Phone Number	Specialty

5. Who treated this injury:

Name	Address	Phone Number	Specialty

B. Do you claim that you have suffered a psychiatric or psychological injury or other emotional injury, as a result of Propecia and/or Proscar use?

Yes _____ No _____

1. **If "yes,"** state the nature of the psychiatric or psychological or other emotional injury(ies) which you claim.

___ Depression
___ Anxiety
___ Other (Please Specify): _____

2. Approximately what date(s) do you claim this injury(ies) occurred?

_____
_____
_____

3. Are you still experiencing the psychiatric, psychological or emotional injury?

Yes ____ No _____

4. Have you sought treatment for this psychiatric, psychological and/or emotional injury?

Yes ____ No ____

a. **If "yes,"** please describe your psychiatric, psychological and/or emotional injury symptoms.

_____
_____
_____

b. Date of diagnosis of psychiatric, psychological and/or emotional injury: _____
(month/day/year)

c. Who first diagnosed this psychiatric or psychological or emotional injury:

Name	Address	Phone Number	Specialty

d. Who treated this psychiatric or psychological or emotional injury:

Name	Address	Phone Number	Specialty

i. Medications prescribed or recommended by the diagnosing or treating doctor for the psychiatric or psychological or emotional injury : _____

_____

_____

ii. Start and end (if any) dates of treatment: _____

C. Have you had discussions with any physician(s) or other health care provider(s) about whether the injury described in Section II(A) and/or Section II(B) above is related to the use of Propecia and/or Proscar? [If you discussed with more than one health care provider, please separately state what was discussed with each individual.]

Yes _____ No _____ Do not recall _____

1. **If "yes,"** please identify:

a. Name(s) of health care provider(s): _____

b. Address(es): _____

c. Specialty(ies): _____

d. Date(s) of discussion(s): _____

e. Do you recall what you were told? Yes _____ No_____

i. **If "yes,"** what were you told? _____

_____

D. Do you claim that your treatment with Propecia and/or Proscar increased your risk of a future injury or harm that you have not yet experienced?

Yes _____ No _____

1. **If "yes,"** identify and describe each and every such future injury or harm you contend you suffered.

_____

_____

_____

E. Have you had any discussions with any physician(s) or other health care provider(s) about whether your treatment with Propecia and/or Proscar puts you at increased risk of future injury or harm? [If you discussed with more than one

health care provider, please separately state what was discussed with each individual.]

Yes _____ No _____ Don't Recall _____

1. **If "yes,"** please identify:

   a. Name of heath care provider(s): _____

   b. Address: _____

   c. Specialty: _____

   d. Date(s) of discussion(s): _____

   e. State what the health care provider told you, including any description of the future injury or harm: _____

F. If you do **not** claim to have suffered a physical, psychological or emotional injury as a result of Propecia and/or Proscar use, state how you have been injured.

G. If you are claiming a psychiatric, psychological or emotional injury in this case, state whether you have ever experienced or have ever been treated for any psychological or psychiatric problem or emotional problem (including depression) **not** related to your use of Propecia and/or Proscar.

Yes _____ No _____

I. **If "yes,"** please provide the following information for each condition:

   a. Describe the symptoms experienced. _____

   b. Name, address, telephone number and specialty of the person who provided the diagnosis and/or treatment.

c. Name and address of the facility or hospital, if any, where the treatment was provided. _____

_____

_____

2. For each provider of care identified in subparagraphs E(1)(a-e) and G(1)(b) of this section, please produce an executed copy of the release form attached hereto as Ex. B, authorizing Merck to obtain your psychological notes and related records generated by any such mental health care practitioner for the past seven (7) years.

III. PERSONAL INFORMATION OF THE PERSON WHO USED PROPECIA AND/OR PROSCAR

A. Name: _____

B. Social Security number: _____

C. Date of birth: _____

D. Place of birth (city, state): _____

E. Provide the full name, address, and age of each of your children:

Name	Address	Age

F. Identify each address at which you have resided during the last ten (10) years, and list approximately when you started and stopped living at each one?

Address	Dates of Residence

G. Within the last ten (10) years, have you been convicted of any felony or a crime involving dishonesty or false statement?

Yes _____ No _____

1. **If "yes,"** please: (1) identify the crime and/or felony, (2) when you were convicted or pled guilty, (3) where you were convicted or pled guilty, (4) whether you were incarcerated, and if so, for how long you were incarcerated.

_____
_____
_____
_____

H. In the last ten (10) years have you ever filed any other type of lawsuit aside from the present suit?

Yes _____ No _____ Do not recall _____

1. **If "yes,"** for each such lawsuit, state (1) the court in which such lawsuit was filed, (2) the case name, (3) the names of the adverse parties, (4) the civil action or docket number assigned to the lawsuit, (5) a description of your claims in the lawsuit, and (6) whether the lawsuit has been resolved and if so, how it was resolved.

_____
_____
_____

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

Yes ____ No ____

1. **If "yes,"** please state:

   a. What branch and the dates of service:_____

   b. Were you discharged for any reason relating to your physical, psychiatric or emotional condition? Yes ____ No ____

      i. **If "yes,"** state what that condition was:_____
      _____
      _____
      _____

   c. Have you ever served in the military overseas? Yes ____ No ____

      i. **If "yes,"** state location and dates: _____
      _____

_____

_____

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

Yes ____ No ____

1. **If "yes,"** state what that condition was:_____

_____

_____

K. Has any healthcare practitioner examined you, treated you, or consulted with other health care practitioners regarding your medical condition at or in affiliation with a Veteran's Administration facility?

Yes ____ No ____

L. Insurance/Claim Information

1. Have you ever filed a worker's compensation claim? Yes ____ No ____

a. **If "yes,"** to the best of your knowledge please state:

i. Year claim was filed:_____

ii. Nature of disability: _____

iii. Approximate dates of disability: _____

iv. Resolution of claim: Denied ___ Granted ____ Other ____

If "other," describe: _____

_____

_____

_____

v. Identify the full name and address of the entity most likely to have records concerning your claim: _____

_____

vi. Full name and address of your employer against whom claim was filed: _____

_____

M. Have you ever filed a social security disability (SSI or SSD) claim?

Yes ____ No ____

1. **If "yes,"** to the best of your knowledge please state:

   a. Year claim was filed: _____

   b. Nature of disability: _____

   c. Approximate dates of disability: _____

   d. Resolution of claim: Denied ____ Granted ____ Other ____

      If "other," describe: _____

   e. Identify the full name and address of the entity most likely to have records concerning your claim: _____
      _____

N. Has any insurance or other company provided medical and/or dental coverage to you (either directly or through a group or employer) for the period beginning ten (10) years before your first use of Propecia and/or Proscar through the present?

Yes _____ No _____ Don't Recall _____

1. **If "yes,"** then as to each such company, separately state:

   a. Name of the company: _____

   b. Address of the company: _____

   c. The account/policy number or designation: _____

   d. Name of primary insured: _____

   e. Dates of coverage: _____

   f. If there are any insurance coverage(s) for which you cannot recall all of the details, please describe those details that you can remember: _____
      _____

IV. EDUCATIONAL HISTORY

Identify each school, college, university and other educational, vocational, and technical institution you have attended, the dates of attendance, courses of study pursued and diplomas, degrees, or certificates awarded.

School	Dates of attendance	Courses/Diplomas/Degrees/Certificates

V. FAMILY INFORMATION

A. Have you ever been married?

Yes _____ No _____

1. **If "yes,"** for each spouse/former spouse state:

a. Spouse's name: _____

b. Dates of marriage: _____

c. Spouse's date of birth: _____

d. Spouse's occupation: _____

e. Spouse's address and phone number: _____

f. If applicable, why did the marriage end (e.g., divorce, death)? _____

_____

g. If applicable, the date the marriage ended: _____

_____

B. Have your grandparents, parents, siblings or children ever had or been diagnosed with benign prostatic hyperplasia (BPH)?

Yes _____ No _____

1. **If "yes,"** state, if you know, (1) the name and relationship of the person to you, (2) the disease(s) that individual has/had, and (3) the date of that individual's diagnosis. _____

_____

_____

_____

VI. OTHER MEDICAL BACKGROUND AND INFORMATION

A. To the best of your knowledge, did you use or take any of the following listed medications or substances BEFORE the injury that you allege you suffered occurred?

1. **If "yes,"** please provide the first and last date on which you took the medication or substance.

Medications	Yes	No	Do not recall	Date First Taken	Date Last Taken
Anticonvulsants – Carbatrol, Gabitril, Lyrica					
Antidepressants – Aplenzin, Celexa, Effexor, Emsam, Lexapro, Marplan, Parnate, Paxil, Prozac, Remeron, Symbyax, Venlafaxine, Wellbutrin, Zyban					
Antipsychotics – Moban, Risperdal, Saphris, Seroquel, Thiothixene, Zyprexa					
Antiarrhythmics – Rythmol					
Appetite suppressants – Adipex					
Attention deficit hyperactivity disorder (ADHD) or sleep disorders medications – Dexedrine					
Barbiturates – Donnatal					
Blood pressure (hypertension) lowering medications – Atacand, Captopril, Cardizem, Catapres, Clorpres, Coreg, Cozaar, DynaCirc, Exforge, Hyzaar, Innopran, Mavik, Nadolol, Prinivil, Tarka, Teveten, Toprol, Valturna					
Cholesterol-lowering medications – Advicor, Lovaza					
Diuretics – Diovan, Dyazide, Indapamide, IV Sodium Diuril, Micardis, Prinzide					
Histamine-2 blockers (ulcers, heartburn, acid) – Axid, Pepcid, Zantac					
Narcotics (Pain relievers) – Avinza, MS Contin, OxyContin, Vicoprofen					
Sedatives (Hypnotics) – Ambien					

Medications used for treatment of enlarged prostates – Avodart					
Medications used for treatment of symptoms of prostate cancer – Lupron					
Medications used for treatment of prostate cancer – Eligard, Novantrone					
Medications used for treatment of symptoms of benign prostatic hyperplasia (BPH) – Uroxatral					
Medications used for treatment of schizophrenia and bipolar disorders – Equetro, Fanapt, Geodon, Invaga					
Medications used for treatment of viral infections – Betaseron, Extavia, Intron A					
Medications used for treatment of bacterial infections – Bicillin					
Medications used for treatment of multiple sclerosis (MS) – Copaxone					
Medications used for treatment of symptoms of Parkinson's disease – Requip					
Medications used for treatment of dementia – Exelon, Namenda					
Medications used for treatment of gastroesophageal reflux disease (GERD) – Nexium					
Medications used for treatment of ALS, Lou Gehrig disease - Rilutek					
Medications used for treatment of symptoms caused by GERD – Protonix					
Medications used for treatment of diabetic gastroparesis– Metozolv ODT					
Medications used for treatment of glaucoma or high pressures in the eye - Betimol, Combigan, Dorzolamide, Timoptic					
Medications used to treat epilepsy and panic disorders – Klonopin, Lamictal, Zonegram					
Medications used for treatment of alcohol-dependency – Campral					

Medications used for secretions of saliva, sweat glands – Evoxac					
Medications used for treatment of loss of appetite and weight loss – Megace					
Medications used for prevention of human immunodeficiency virus (HIV) cells from multiplying – Norvir					

B. Were you taking any other prescription medicines in the five (5) years prior to developing the injury you are claiming in this action?

Yes _____ No _____

1. **If "yes,"** please list the medications, the first and last dates of ingestion, and reasons for taking each.

Medication	**First date of Ingestion**	**Last Date of Ingestion**	**Reason for Taking Medication**

C. Have you participated in any clinical trials or taken any experimental drugs?

Yes _____ No _____

1. **If "yes,"** please indicate when you participated in such trials, where the trials took place, which drugs you took, and for what condition you took such drugs. _____
_____
_____
_____

D. Smoking/Tobacco Use History:

1. Do you now or have you ever smoked or used tobacco products?

Yes_____ No _____

a. **If "yes,"** indicate with an "X" the answer and fill in the blanks applicable to your history of smoking and/or tobacco use

i. Current smoker of cigarettes ____; cigars ____; pipe tobacco ____; or user of chewing tobacco/snuff ____.

and Amount smoked or used: on average _____ per day for _____ years.

ii. Past smoker of cigarettes ____; cigars ____; pipe tobacco ____; or used chewing tobacco/snuff ____.

and Date on which smoking/tobacco use ceased: _____

and Amount smoked or used: on average _____ per day for _____ years.

E. Alcoholic Beverage Consumption History

1. Do you now drink or have you in the past drunk alcohol during the period you took Propecia and/or Proscar (beer, wine, whiskey, etc.)?

Yes ____ No ____

a. **If "yes,"** fill in the appropriate blank with the number of drinks that represents your average alcohol consumption during the period you were taking Propecia and/or Proscar up to the time that you sustained the injuries alleged in the complaint:

_____ drinks per week, or
_____ drinks per month, or
_____ drinks per year.

F. Have you ever experienced or been diagnosed or treated for any condition related to sexual dysfunction **prior** to taking Propecia and/or Proscar?

Yes ____ No ____

1. **If "yes"** above, please provide the following information for each condition:

Condition	**Name and Address of Diagnosing or Treating Doctor/Hospital**	**Approximate Onset Date of Condition**

VII. PROPECIA AND PROSCAR USE

A. Identify which of the following medications you have taken:

		Yes	No	Do not recall
1.	PROPECIA®			
2.	PROSCAR®			
3.	Finasteride			
4.	Avodart			
5.	Dutasteride			
6.	Jalyn			
7.	Tamsulosin			
8.	Flomax			

B. Complete the following information for each drug identified above:

Drug	Dates of Use	Dosage	Full Name and Address of Prescribing Physician & Specialty	Condition(s) Treated	Address of Pharmacy Where Prescription was Filled	Date of Last Use	Date of Diagnosis	Full Name and Address of Physician Who First Diagnosed Condition & Specialty	Treatment

C. For each medication identified in Section VII(A), list any other treatment you received (surgery, medications taken or prescribed) for the injury, illness, disease, condition or disability: _____

_____

_____

D. Did you receive any samples of Propecia and/or Proscar? Yes ____ No ____

1. **If "yes,"** provide the following:

a. Identify the name and address of the clinic, hospital or medical practice where you received samples: _____

_____

b. Identify the approximate date(s) when the samples were provided:

_____

E. At any time leading up to and including the date you first began taking Propecia and/or Proscar, did you suffer from any other physical injuries, illnesses or disabilities (including but not limited to those listed in Section VI(F)) other than the disease or condition identified in VII(B) above?

Yes _____ No _____

1. **If "yes,"** identify:

a. Injury, illness, or disability: _____

b. Symptom(s): _____

c. Date(s) of onset: _____

d. Date(s) of diagnosis: _____

e. Name, address, telephone number and specialty of the person who first diagnosed the injury, illness or disability._____

_____

F. Did you see any written, televised or internet-based advertising or labeling materials regarding Propecia and/or Proscar prior to or during the time you took Propecia and/or Proscar?

Yes _____No _____ Do not recall _____

1. **If "yes,"** state which written, televised or internet-based advertising or labeling materials you recall seeing regarding Propecia and/or Proscar and when you saw such advertising or labeling materials, excluding any such materials that are covered by the Attorney-Client or Work Product Privileges._____

_____

_____

G. Have you ever visited any website (including any chat rooms) regarding Propecia and/or Proscar?

Yes _____ No _____ Do not recall ____

1. **If "yes,"** identify to the best of your recollection all websites and chat rooms visited that you recall and the approximate dates of visit, excluding any such visits that are covered by the Attorney-Client or Work Product Privileges _____

_____

_____

H. Did you receive any written and/or oral instructions or information regarding Propecia and/or Proscar before you took Propecia and/or Proscar?

Yes ____ No ____ Don't Recall _____

1. **If "yes,"** please answer the following:

a. What date did you receive the instructions or information about Propecia and/or Proscar? _____

_____

_____

b. Which physician(s) or other health care provider(s) gave you the written and/or oral instructions or information about Propecia and/or Proscar?_____

_____

_____

c. What written instructions or information did you receive about Propecia and/or Proscar?_____

_____

_____

d. What oral instructions or information did you receive about Propecia and/or Proscar? _____

_____

_____

VIII. MONETARY LOSS CLAIMS

A. Are you making a wage loss claim for either your present or previous employment due to your injury from Propecia and/or Proscar?

Yes ____ No ____

1. **If "yes,"** identify your annual income at the time of the injury alleged in Section II(A) and/or Section II(B): _____

B. Are you making a claim for loss of earning potential going forward into the future as a result of your Propecia and/or Proscar injuries?

Yes _____ No ____

1. **If "yes,"** describe the nature of your loss of earning potential claim:

_____
_____
_____
_____

C. Have you paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of Propecia and/or Proscar and for which you seek recovery in the action you have filed?

Yes _____ No _____

1. **If "yes,"** state the total amount of such expenses at this time: $_____

D. Has your insurer, or any other entity or person, paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of Propecia and/or Proscar and for which you seek recovery in the action you have filed.

Yes _____ No _____

1. **If "yes,"** state an approximate total amount of such expenses known at this time (if you do not know, you may answer "I do not know"): $_____

E. Please provide an itemized statement of the nature and amount of all damages you are claiming. _____
_____
_____
_____

IX. WITNESSES

To the best of your knowledge identify all persons (not identified elsewhere in this questionnaire) who you believe possess information concerning your injury, your current medical condition, the medical condition for which you took Propecia and/or Proscar your claims in this case and for each and state their name, address, telephone number and a description of the information you believe they possess.

Name	Address	Telephone Number	Description of Information

X. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

Identify the following:

A. Your current family and/or primary care physician:

Name	Address	Specialty	Approximate Dates of Treatment

B. Identify each of your other primary care physicians for the ten (10) years prior to the date of your first use of Propecia and/or Proscar through the present.

Name	Address	Specialty	Approximate Dates of Treatment

C. Each hospital, clinic, or healthcare facility where you have received inpatient treatment or been admitted as a patient during the ten (10) years prior to the date of your first use of Propecia and/or Proscar through the present.

Name	Address	Admission Dates	Reason for Admission

D. Each hospital, clinic, or healthcare facility where you have received outpatient treatment (including treatment in an emergency room) during the ten (10) years prior to the date of your first use of Propecia and/or Proscar through the present.

Name	Address	Treatment Dates	Reason for Treatment

E. Each pharmacy that has dispensed medication to you in the ten (10) years prior to the date of your first use of Propecia and/or Proscar through the present.

Name	Address

DECLARATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact sheet is true and correct to the best of my knowledge, information and belief, and I have supplied the authorizations attached to this declaration.

Signature _____ Print Name _____ Date _____

XI. PERSONAL INFORMATION OF LOSS OF CONSORTIUM AND REPRESENTATIVE PLAINTIFFS

If you are a representative or loss of consortium plaintiff, please provide your personal response to these questions.

A. Last Name: _____

First Name: _____

Middle Name or Initial: _____

B. Maiden or other names used or by which you have been known: _____

_____

C. Social Security Number: _____

D. Present Street Address: _____

_____

City State Zip Code

E. Identify each address at which you have resided during the last ten (10) years, and list when you started and stopped living at each one:

Address	**Approximate Date From**	**Approximate Date To**

F. Identify each high school, college, university or other education institution (except grade school) you have attended, the dates of attendance, courses of study pursued, and diplomas or degrees awarded:

School	**Dates of attendance**	**Courses/Diplomas/Degrees/Certificates**

G. Are you are seeking any form of wage loss claim?

Yes ____ No ____

1. **If "yes,"** provide the following Employment Information for the last ten (10) years:

a. Current employer (if not currently employed, last employer):

_____
Name

_____
Address

_____
Dates of Employment

_____
Occupation/Job Duties

_____
Salary/Bonus/Overtime

H. Date and Place of Birth: _____

I. Sex: Male ___ Female ___

J. Date and Place of Marriage: _____

K. Have you ever been convicted of a crime of dishonesty in the last ten (10) years:

Yes ____ No ____

1. **If "yes,"** where, when and the crime. _____
_____

DECLARATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact sheet is true and correct to the best of my knowledge, information and belief, and I have supplied the authorizations attached to this declaration.

_____	_____	_____
Signature of consortium plaintiff	Print Name	Date

DOCUMENTS AND THINGS

Please produce the documents and things requested below, that are in your possession not including those items covered by the Attorney-Client or Work Product Privileges. If you withhold a document or information otherwise discoverable by claiming that it is privileged or otherwise protected, you shall make any such claim expressly and describe the nature of the information or document not produced or disclosed in a manner that enables other parties to assess the applicability of the privilege or protection, in accordance with the requirements of Fed. R. Civ. P. 26(b)(5).

1. For each health care practitioner who has examined you, treated you, or consulted with other health care practitioners regarding your medical or dental condition within ten (10) years of your first use of Propecia and/or Proscar to the present, produce an executed copy of the release form attached to this Plaintiff's Fact sheet as **Ex. A**, authorizing Merck to obtain medical records, including all radiological or imaging records from each health care practitioner and/or in your possession.

2. For each hospital, clinic or any other facility at which you have been treated for any medical condition within ten (10) years of your first use of Propecia and/or Proscar to the present, produce an executed copy of the release form attached as **Ex. A**, authorizing Merck to obtain medical records from each such hospital, clinic or any other facility.

3. For any health care practitioner that examined you, treated you, or consulted with other health care practitioners regarding your medical condition at or in affiliation with a Veteran's Administration facility, please produce an executed copy of the release form attached as **Ex. B**, authorizing Merck to obtain medical records from each health care practitioner.

4. For any psychologist, psychiatrist or other mental health care practitioner that treated you within seven (7) years of your first use of Propecia and/or Proscar, please produce an executed copy of the release form attached as **Ex. C**, authorizing Merck to obtain mental health records from each mental health care practitioner.

5. If you have been a claimant in a worker's compensation, Social Security or other disability proceeding, please produce an executed copy of the release form attached as **Ex. D**, authorizing Merck to obtain all documents discussing, describing or memorializing your requests for Social Security, disability insurance, or workers' compensation benefits.

6. If you are making a wage loss or loss of earning capacity claim, for each of your employers identified, please produce two executed copies of the release forms attached as **Ex. E**, permitting Merck to obtain your employment records, including W-2 forms and/or 1099 forms from three years prior to the date of the claimed wage loss or loss of earning capacity.

7. If you served in the military, please produce an executed copy of Standard Form 180 attached as **Ex. F**, permitting Merck to obtain your military personnel, service, and health records.

8. For each health insurance company or other organization that has insured you from ten years (10) years prior to your first use of Propecia and/or Proscar to the present, produce an executed copy of the authorization, attached as **Ex. A**, authorizing Merck to obtain all insurance records from each such company.

9. Please produce any documents, in your possession, constituting, concerning or relating to product use instructions, product warnings, package inserts, handouts or other materials distributed with or provided to you in connection with your use of Propecia and/or Proscar.

10. Please produce any documents, in your possession, containing copies of advertisements, written or Internet materials or promotions for Propecia and/or Proscar, not including those items covered by the Attorney-Client or Work Product Privileges.

11. Please produce any documents, in your possession of copies of all printouts from websites you visited regarding Propecia and/or Proscar, regarding your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges.

12. Please produce any documents including copies of transcripts, in your possession of Internet chat room discussions in which you participated regarding Propecia and/or Proscar, your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges.

13. Please produce any documents including email, in your possession relating to Propecia and/or Proscar, your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges.

14. Please produce any documents, in your possession relating to Propecia and/or Proscar or any alleged health risks or hazards related to these drugs in your possession at or before the time of your claimed injury.

15. Please produce any documents, in your possession that you (and not your lawyer) obtained directly or indirectly from Merck related to Proscar or Propecia.

16. Please produce any documents, in your possession of all diaries, calendars or any other writings or recordings made by you, or by any other person, describing, discussing, explaining or referring to the injuries, damages, or causes of action alleged by you in the Complaint and/or referring to the underlying illness or disease for which you received Propecia and/or Proscar, not including those items covered by the Attorney-Client or Work Product Privilcges.

17. Please produce any documents, in your possession that you (and not your attorneys) obtained from any source relatcd to Propecia and/or Proscar or to the allegcd effects of

such medications, not including those items covered by the Attorney-Client or work Product Privileges.

18. If you are claiming any loss from medical expenses, please produce any documents copies of all bills from any physician, hospital pharmacy or other health care provider that are in your possession.

19. If this claim is a claim alleging Propecia and/or Proscar caused the wrongful death of the Decedent, Decedent's death certificate (if applicable).