

IN RE CALIFORNIA COORDINATED DIET DRUG PROCEEDINGS
JCCP-4032
PLAINTIFF'S FACT SHEET

This Fact Sheet and the attached List of Medical Providers and Other Sources of Information must be completed by each plaintiff in JCCP-4032 who used diet drugs or who is the representative of a person or the estate of a deceased person who used diet drugs.

I. CASE INFORMATION

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

1. Case Caption: _____

2. JCCP Civil Action No.: _____

3. Court in which action originally brought (transferor district):

4. Original civil action number in the transferor court.
Civil Action No: _____

5. Please state name, address, telephone number, fax number and E-mail address of principal attorney representing you.

Name

Firm

City, State and Zip Code

Telephone number

Fax number

E-mail address

B. If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person or minor), please complete the following:

1. _____
Your Name

2. _____
Street Address

II. PERSONAL INFORMATION

A. Last Name: _____

First Name: _____

Middle Name or Initial: _____

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

C. Present Street Address: _____

City

State

Zip Code

D. Current or last employer:

Name

Address

Dates of Employment

Occupation

E. Social Security Number: _____

F. Date of Birth: _____

G. Sex: Male _____ Female _____

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

Yes _____ No _____

If yes, please state:

1. What branch and the dates of service.

Were you discharged for any reason relating to your health or physical condition?

Yes _____ No _____

2. If yes, state what that condition was.

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

Yes _____ No _____

If yes, state what the condition was.

J. Have you ever filed a worker's compensation claim?

Yes _____ No _____

If yes, please state

1. Year claim was filed: _____

2. Where claim was filed: _____

3. Claim/docket number, if applicable _____

4. Nature of disability: _____

5. Period of disability: _____

[Attach additional sheets if necessary to describe more than one claim]

K. Have you ever filed a social security disability claim?

Yes _____ No _____

If yes, please state

1. Year claim was filed: _____

2. Where claim was filed: _____

3. Nature of disability: _____

4. Period of disability: _____

[Attach additional sheets if necessary to describe more than one claim]

L. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury?

Yes _____ No _____

If so, state the court in which such action was filed and the civil action or docket number assigned to each such claim, action or suit.

M. Have you ever been convicted of a felony within the last 10 years?

Yes _____ No _____

III. FAMILY INFORMATION

A. Are you currently married?

Yes _____ No _____

B. Has your spouse filed a loss of consortium claim?

Yes _____ No _____

C. Spouse's name: _____

D. Spouse's date of birth: _____

E. Spouse's occupation: _____

IV. MEDICAL CONDITION AND BACKGROUND

A. Do you currently suffer from any physical injuries, illnesses or disabilities?

Yes _____ No _____

B. If the answer is yes, please state the following:

1. Identify the injury, illness, or disability and date of onset:

Injury, illness or disability

Date of onset

2. By whom first diagnosed:

Name

Address (if not otherwise provided)

C. Height: _____

D. Weight before use of Pondimin, Redux or phentermine: _____

E. Current Weight: _____

F. To the best of your knowledge, have you ever used:

1. Ergotamine preparations (Cafergot)

Yes _____ No _____

If yes, date first taken: _____

Date last taken: _____

2. Any medication for migraine headaches

Yes _____ No _____

If yes, identify the medication _____

Date first taken: _____

Date last taken: _____

G. Have you used prescription medications (other than Pondimin, Redux or phentermine), herbal preparations, or over the counter products to control or reduce your weight

Yes _____ No _____

If yes, state

Product

approx. dates of use

Product _____ approx. dates of use _____

Product _____ approx. dates of use _____

H. Smoking history [check whichever is applicable]

1. never smoking cigarettes _____

2. past smoker of cigarettes _____

date on which smoking ceased _____

amount smoked: _____ packs per day for _____ years

3. current smoker of cigarettes _____

amount smoked: _____ packs per day for _____ years

I. If you claim psychological or emotional injury as a consequence of diet drugs, state whether you have experienced or been treated for any psychological, psychiatric or emotional problem prior to the use of Pondimin, Redux or phentermine.

Yes _____ No _____

If yes, state:

1. Name and address of each person who treated you

a. _____
Name

Address (if not otherwise provided)

b. _____
Name

Address (if not otherwise provided)

c. _____
Name

Address (if not otherwise provided)

2. Condition for which treated

3. When treated

J. To the best of your knowledge, have you been told by a doctor or any other medical professional, that you have, may have or had any of the following:

- | | | | | | |
|-----|---|-----|-------|----|-------|
| 1. | Hypertension or high blood pressure | Yes | _____ | No | _____ |
| 2. | Heart Murmur | Yes | _____ | No | _____ |
| 3. | Stroke | Yes | _____ | No | _____ |
| 4. | Blood clot to the lung (pulmonary embolism) | Yes | _____ | No | _____ |
| 5. | Chronic lung disease | Yes | _____ | No | _____ |
| 6. | Immune system disease or dysfunction (including AIDS or HIV) | Yes | _____ | No | _____ |
| 7. | Rheumatic fever | Yes | _____ | No | _____ |
| 8. | Cirrhosis, hepatitis or other liver disease | Yes | _____ | No | _____ |
| 9. | Pulmonary hypertension | Yes | _____ | No | _____ |
| 10. | Pulmonary venous hypertension | Yes | _____ | No | _____ |
| 11. | Primary pulmonary hypertension | Yes | _____ | No | _____ |
| 12. | Heart valve prolapse or regurgitation | Yes | _____ | No | _____ |
| 13. | Cardiac arrhythmias | Yes | _____ | No | _____ |
| 14. | Collagen vascular disease | Yes | _____ | No | _____ |
| 15. | Bacterial endocarditis | Yes | _____ | No | _____ |
| 16. | Lupus | Yes | _____ | No | _____ |
| 17. | Rheumatoid Arthritis | Yes | _____ | No | _____ |
| 18. | Connective Tissue Disease | Yes | _____ | No | _____ |
| 19. | Other autoimmune disease | Yes | _____ | No | _____ |
| | If Yes, specify: _____ | | | | |
| 20. | Scarlet Fever | Yes | _____ | No | _____ |
| 21. | Carcinoid syndrome | Yes | _____ | No | _____ |
| 22. | Sleep apnea | Yes | _____ | No | _____ |
| 23. | Heart valve lesions | Yes | _____ | No | _____ |
| 24. | Heart valve prolapse | Yes | _____ | No | _____ |
| 25. | Congenital aortic valve abnormalities, such as unicuspid, bicuspid or quadricuspid aortic valve, ventricular septal defect associated with aortic regurgitation | Yes | _____ | No | _____ |
| 26. | Congenital mitral valve abnormalities, such as parachute valve, cleft of the mitral valve associated with atrial septal defect | Yes | _____ | No | _____ |
| 27. | Other congenital abnormality of heart | Yes | _____ | No | _____ |
| 28. | Aortic dissection involving the aortic root and/or aortic valve | Yes | _____ | No | _____ |
| 29. | Aortic sclerosis | Yes | _____ | No | _____ |

- 30. Aortic root dilation Yes _____ No _____
- 31. Aortic stenosis Yes _____ No _____
- 32. Chordae tendineae rupture or papillary muscle rupture Yes _____ No _____
- 33. Myocardial infarction Yes _____ No _____

K. If you responded yes to any of the above, please identify the condition, the date of onset and state the name of the physician or other medical professional and, if not provided in the accompanying list, the address of the physician who made the diagnosis or informed you of the condition.

1. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

2. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

3. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

L. Please indicate whether you have received any of the following treatments:

Heart, lung or other chest surgery Yes _____ No _____

For what condition?

When? _____

Treating physician:

M. To the best of your knowledge, state whether any of the following tests were administered BEFORE your use of Pondimin, Redux and/or phentermine.

- | | | | |
|----|---|-----------|----------|
| 1. | Echocardiogram | Yes _____ | No _____ |
| 2. | Electrocardiogram | Yes _____ | No _____ |
| 3. | Cardiac or pulmonary artery catheterization | Yes _____ | No _____ |
| 4. | Pulmonary function test | Yes _____ | No _____ |
| 5. | Perfusion lung scan | Yes _____ | No _____ |
| 6. | Chest x-ray | Yes _____ | No _____ |
| 7. | Arterial, cardiac or pulmonary angiogram | Yes _____ | No _____ |
| 8. | Cardio-pulmonary or thallium stress test | Yes _____ | No _____ |
| 9. | Other diagnostic test or imaging of the heart, lungs or pulmonary arteries or arterial pressure | Yes _____ | No _____ |

N. For each test for which you answered yes, identify the treating physician and approximate date of the test.

Treating Physician	Approximate date

O. If an echocardiogram was taken BEFORE your use of Pondimin, Redux and/or phentermine, complete the following chart as to the results or attach a copy of the test report:

	None	Trace	Mild	Moderate	Severe
Mitral Valve Regurgitation	_____	_____	_____	_____	_____
Tricuspid Valve Regurgitation	_____	_____	_____	_____	_____
Aortic Valve Regurgitation	_____	_____	_____	_____	_____
Pulmonary Valve Regurgitation	_____	_____	_____	_____	_____

P. To the best of your knowledge, state which of the following tests was administered AFTER your use of Pondimin, Redux or phentermine.

- | | | | |
|----|-------------------|-----------|----------|
| 1. | Echocardiogram | Yes _____ | No _____ |
| 2. | Electrocardiogram | Yes _____ | No _____ |

- 3. Cardiac or pulmonary artery catheterization Yes _____ No _____
- 4. Pulmonary function test Yes _____ No _____
- 5. Perfusion lung scan Yes _____ No _____
- 6. Chest x-ray Yes _____ No _____
- 7. Arterial, cardiac or pulmonary angiogram Yes _____ No _____
- 8. Cardio-pulmonary or thallium stress test Yes _____ No _____
- 9. Other diagnostic test or imaging of the heart, lungs or pulmonary arteries or arterial pressure Yes _____ No _____

Q. For each test for which you answered yes, identify the treating physician and approximate date on which the tests were done.

_____ Treating Physician _____ Approximate date

R. If an echocardiogram was taken **AFTER** your use of Pondimin, Redux and/or phentermine, complete the following chart as to the results or attach a copy of the test results:

	None	Trace	Mild	Moderate	Severe
Mitral Valve Regurgitation	_____	_____	_____	_____	_____
Tricuspid Valve Regurgitation	_____	_____	_____	_____	_____
Aortic Valve Regurgitation	_____	_____	_____	_____	_____
Pulmonary Valve Regurgitation	_____	_____	_____	_____	_____

V. DIET DRUG USE

A. Please complete the following chart with respect to each diet medication you have taken: [if you took more than one type of phentermine product, please complete this chart, including a description, for each separate phentermine product.²]

Drug Name: Generic/Brand	Description: Color/ Shape/Writing/ Name	Approximate Date First Taken	Approximate Date Last Taken	Prescribed/ Dispensed by: (Doctor or Clinic)
dexfenfluramine/Redux	15 mg. capsule; white cap with			

² Applicable only if suing a phentermine manufacturer or distributor.

	black stripe; "REDUX"			
fenfluramine/Pondimin	orange round tablet; 20 mg.			
phentermine				
phentermine				
phentermine				

B. If you took phentermine, please state the brand name(s) and manufacturer/distributor of the phentermine product(s) you took, to the extent known to you.³

1. Brand Name: _____

Manufacturer/Distributor _____

2. Brand Name: _____

Manufacturer/Distributor _____

C. If you took phentermine, please check the description of each phentermine product you took.⁴

1. white capsule with blue cap; "Adipex-P" - 37.5" on cap and two dark stripes on body _____

2. white caplet with blue spots; 37.5 mg.; "LEMMON" - "99" with center score _____

3. Peanut shaped, green tablet imprinted with "S" on both sides; 37.5 mg. _____

4. 30mg.; blue and clear capsule with blue and white beads; imprinted with "BMP 147," "Fastin" and/or "Beecham" _____

5. white tablet with blue dots; oval; 37.5 mg. _____

6. green round tablet; 8 mg. _____

7. orange round tablet; 8 mg. _____

8. yellow oblong tablet; 37.5 mg. _____

9. black-yellow capsule; 37.5 mg. _____

³ Applicable only if suing a phentermine manufacturer or distributor.

⁴ Applicable only if suing a phentermine manufacturer or distributor.

10. black-black capsule; 37.5 mg. _____
11. brown-clear capsule; 37.5 mg. _____
12. green-clear capsule; 37.5 mg. _____
13. red-black capsule; 37.5 mg. _____
14. yellow-yellow capsule; 37.5 mg. _____
15. yellow-yellow capsule; 30 mg. _____
16. green-clear capsule; 30 mg. _____
17. brown-clear capsule; 30 mg. _____
18. black-black capsule; 30 mg. _____
19. blue-clear capsule; 30 mg. _____
20. gray-yellow capsule; 15 mg. _____
21. yellow-gray capsule; 18.75 mg. imprinted "18.75" _____
22. yellow-gray capsule; 15 mg. imprinted "E882" _____
23. yellow-yellow capsule; 30 mg.; imprinted "E647" _____
24. blue-white gel capsule; "E5000"; 30 mg. _____
25. 37.5 mg. tablet with blue dots _____
26. Resin; yellow-yellow capsule imprinted with "IONAMIN 30" _____
27. Resin; yellow-gray capsule imprinted with "IONAMIN 15" _____
28. Hard yellow gel capsule; 30 mg; "RPC-69" _____
29. green-clear gel capsule; 37.5 mg.; imprinted "ABANA" and "217" _____
30. black capsule _____
31. yellow capsule _____
32. yellow-gray capsule _____

- 33. blue-clear capsule _____
- 34. black gel capsule; 30 mg.; imprinted "Zantryl" _____
- 35. Other:
Please describe: _____

- 36. I can't remember what the product looked like _____

D. For each Pondimin, Redux, or phentermine prescription taken by you, set forth the approximate date of any product change or any change or interruption in dosage.

Product	Dosage Change/Interruption/ Product Change	Approximate Date
Product	Dosage Change/Interruption/ Product Change	Approximate Date
Product	Dosage Change/Interruption/ Product Change	Approximate Date

E. Did you lose weight while on Pondimin, Redux or Phentermine?

Yes _____ No _____

If the answer is yes, state the amount of weight you lost _____ and state the period during which the weight loss was achieved _____.

F. State your high and low weight over the past ten years.

High _____ lbs. Approximate Date _____
 Low _____ lbs. Approximate Date _____

VI. INJURY CLAIMS

A. 1. Have you had discussions with any doctor about whether your condition is related to the use of diet drugs?

Yes _____ No _____ Don't know _____

2. If yes, check one of the following:
- a. I was told my condition is related to the use of diet drugs. _____
 - b. I was told my condition is not related to the use of diet drugs. _____
 - c. I was told my condition may be related to the use of diet drugs. _____
 - d. I was told by the doctor that he does not know whether my condition is related to the use of diet drugs. _____
 - e. I don't recall what I was told. _____

3. Identify the doctor or doctors

Name

Address (if not otherwise provided)

4. If discussed with more than one doctor, please copy and complete Parts 2 and 3 for each.

B. State whether you requested any doctor or clinic provide you with diet drugs, and, if yes, identify the drug requested.

Yes _____ No _____

If yes, identify the drug requested _____

C. Were you given any written instructions or warnings regarding the use of Pondimin, Redux and/or phentermine?

Yes _____ No _____

If yes, state when the written instructions or warnings were given and identify each person or entity from whom you received the warnings or instructions.

Approximate date

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

D. Were you given any oral instructions or warnings regarding the use of Pondimin, Redux and/or phentermine?

Yes _____ No _____

If yes, state when the written instructions or warnings were given and identify each person or entity from whom you received the warnings or instructions.

Approximate date

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

E. If you claim or expect to claim that you lost earnings or impairment of earning capacity as a result of any condition which you believe was caused by your use of diet drugs:

1. Complete the following information with respect to your employment for the past ten years.

Employers for Past Ten ears	Address	Type of Business/Position	Dates of Employment

2. State the total amount of time which you have lost from work as a result of any condition which you claim or believe was caused by your use of diet drugs and the amount of income which you lost.

3. State your earned income for each of the last five years.

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

- F. Have you paid or incurred any medical expenses, including amounts billed or paid by insurers and other third party payors, which are related to any condition which you claim or believe was caused by your use of diet drugs and for which you seek recovery in the action which you filed?

Yes _____ No _____

If yes, state the total amount of such expenses at this time. \$ _____

VII. DOCUMENTS

Attach the following documents to this declaration, to the extent that such documents are currently in your possession or in the possession of your lawyers.

- A. A copy of all prescriptions for diet medications, exemplars of any unused diet medications you received as a result of such prescriptions, receipts, physician or office records, drug containers, packaging and other records which show each diet drug you have taken, the period during which you have taken each, the dosage of each diet drug and the frequency with which you took each drug.
- B. A copy of all medical records from any physician, hospital or health provider, who treated you for any disease, condition or symptom referred to in your response to questions in Part V.
- C. To the extent not included in the foregoing, all records relating to any examination by a physician or other health care provider, conducted for any purpose, other than psychiatric or psychological evaluation, in the period beginning five (5) years prior to the date upon which you first used phentermine, Pondimin, Redux and continuing to date.
- D. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.
- E. All diagnostic tests or test results including reports of echocardiograms.
- F. Copies of all documents from physicians, health or weight loss clinics or others relating to the use of diet drugs, or to any condition you claim is related to the use of diet drugs.
- G. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, height and weight charts, pharmacy handouts or other materials distributed with or provided to you when your prescriptions for diet medications were filled.
- H. All documents in the nature of records regarding weight gain and weight loss such as charts recording weight loss, diaries of weight loss efforts, notes or descriptions

of medicines or other substances used to control or reduce your weight, and the like.

- I. If you claim you have suffered a loss of earnings or earning capacity, your federal tax returns for each of the last five (5) years.
- J. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.

VIII. INTERMEDIATE OPT OUT CLAIMS [To be completed only by persons who are asserting a right to sue pursuant to the “Intermediate Opt-Out” provisions of the Nationwide Class Action Settlement Agreement with American Home Products Corporation.]

- A. Indicate which of the following medical conditions you claim to have that entitle you to assert an “Intermediate Opt-Out” claim:

_____ Mild or greater regurgitation of the aortic heart valve as defined in Section I.22.b. of the Settlement Agreement

_____ Moderate or greater regurgitation of the mitral heart valve as defined in Section I.22.b. of the Settlement Agreement

- B. With respect to the echocardiogram showing mild or greater aortic and/or moderate or greater mitral valve regurgitation that you claim qualifies you for the exercise of an Intermediate Opt-Out, complete the information in the chart below.

Date Echocardiogram Performed	Name/Address of Facility Where Performed	Name/Address of Person Who Evaluated	*Aortic Regurgitation?	*Mitral Regurgitation?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*Specify: Mild, Moderate, or Severe. If some other description of the degree of regurgitation appears on the evaluation of the echocardiogram (e.g., “mild-moderate”), that description should be in this column.

C. Have you ever been diagnosed with mild or greater regurgitation of the aortic valve or moderate or greater regurgitation of the mitral valve by an echocardiogram conducted prior to September 30, 1999?

_____ YES

_____ NO

If “yes,” with respect to any echocardiogram conducted prior to September 30, 1999 showing mild or greater aortic and/or moderate or greater mitral valve regurgitation, complete the information in the chart below:

Date Echocardiogram Performed	Name/Address of Facility Where Performed	Name/Address of Person Who Evaluated	*Aortic Regurgitation?	*Mitral Regurgitation?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

First generation or best available, clear copies of the videotapes, and if available CD-ROMS, of all echocardiograms referenced in VIII.B above must be attached to this Fact Sheet.

Attach copies of all of the following non-privileged⁵ documents in your or your attorneys’ possession relating to the echocardiogram referenced in VIII.B. above: all reports and worksheets of the cardiologist, sonographer, and technician; all forms or other documents concerning the medical history and medical condition of the plaintiff provided to or prepared by the cardiologist, sonographer, or technician in connection with the echocardiographic examination; all documents reflecting any limitation of the cardiologist’s, sonographer’s, technician’s or echocardiogram facility’s medical or legal responsibility for the conduct of or any opinion reached regarding the echocardiographic examination; all instructions provided by the plaintiff’s counsel or representative of the plaintiff’s counsel to the cardiologist, sonographer, or technician concerning the performance or interpretation of the echocardiographic examination; and all other documents reflecting any non-privileged opinion, findings, observations, protocol, or procedures of the reporting cardiologist, sonographer, technician or echocardiogram facility regarding the echocardiographic examination.]

Copies of all documents submitted by the Class Member to the AHP Settlement Trust must be attached to this Fact Sheet.

⁵ For any document that would be responsive to the requests set forth below but for a claim or assertion of privilege or work product doctrine, identify the claim of exemption from discovery expressly and describe the nature of the documents not produced so as to enable other parties to assess the applicability of the privilege or protection.

IX. BACK END OPT OUT CLAIMS [To be completed only by persons who are asserting a right to sue pursuant to the “Back-End Opt-Out” provisions of the Nationwide Class Action Settlement Agreement with American Home Products Corporation.]

A. With respect to each echocardiogram upon which you base your claim that you were timely diagnosed with FDA Positive or Mild Mitral heart valve regurgitation, complete the information in the chart below:

	Date Echocardiogram Performed	Name/Address of Facility Where Performed	Name/Address of Person Who Evaluated	*Aortic Regurgitation?	*Mitral Regurgitation?
1.	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

*Specify: Mild, Moderate, or Severe. If some other description of the degree of regurgitation appears on the evaluation of the echocardiogram (e.g., “mild-moderate”), that description should be in this column.

B. Specify what level of valvular regurgitation you claim to now have that would allow you to exercise a Back End Opt-Out:

	Date Echocardiogram Performed	Name/Address of Facility Where Performed	Name/Address of Person Who Evaluated	*Aortic Regurgitation?	*Mitral Regurgitation?
1.	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

*Specify: Mild, Moderate, or Severe. If some other description of the degree of regurgitation appears on the evaluation of the echocardiogram (e.g., “mild-moderate”), that description would be in this column.

C. In addition to the heart valve regurgitation identified above, what other injuries, complications, or adverse health effects do you claim to have that entitle you to exercise a "Back End Opt-Out"? _____

Approximate date of diagnosis: _____

Name and address of diagnosing M.D.: _____

D. Have you ever been diagnosed with mild or greater regurgitation of the aortic valve or moderate or greater regurgitation of the mitral valve by an echocardiogram conducted prior to September 30, 1999?

_____ YES

_____ NO

If "yes," with respect to any echocardiogram conducted prior to September 30, 1999 showing mild or greater aortic and/or moderate or greater mitral valve regurgitation, complete the information in the chart below:

Date Echocardiogram Performed	Name/Address of Facility Where Performed	Name/Address of Person Who Evaluated	*Aortic Regurgitation?	*Mitral Regurgitation?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

First generation or best available, clear copies of the videotapes, and if available, CD-ROMS, of all echocardiograms referenced in IX.A above must be attached to this Fact Sheet.

Attach copies of all of the following non-privileged⁶ documents in your or your attorneys' possession relating to the echocardiograms referenced in IX.A and IX.B above: all reports and worksheets of the cardiologist, sonographer, and technician; all forms or other documents concerning the medical history and medical condition

⁶ For any document that would be responsive to the requests set forth below but for a claim or assertion of privilege or work product doctrine, identify the claim of exemption from discovery expressly and describe the nature of the documents not produced so as to enable other parties to assess the applicability of the privilege or protection.

of the plaintiff provided to or prepared by the cardiologist, sonographer, or technician in connection with the echocardiographic examination; all documents reflecting any limitation of the cardiologist, sonographer, technician or echocardiogram facility's medical or legal responsibility for the conduct of or any opinion reached regarding the echocardiographic examination; all instructions provided by the plaintiff's counsel or representative of the plaintiff's counsel to the cardiologist, sonographer, or technician concerning the performance or interpretation of the echocardiographic examination; and all other documents reflecting any non-privileged opinion, findings, observations, protocol or procedures of the reporting cardiologist, sonographer, technician or echocardiogram facility regarding the echocardiographic examination.]

Copies of all documents submitted by the Class Member to the AHP Settlement Trust must be attached to this Fact Sheet.

DECLARATION

I declare under penalty of perjury under the laws of the State of California that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have completed the List of Medical Providers and Other Sources of Information appended thereto, which is true and correct to the best of my knowledge, information and belief, that I have supplied the echocardiogram videotapes, and if available CD-ROMs, required to be produced pursuant to Part VIII or IX of this Fact Sheet, if applicable, that I have supplied all the documents requested in part VII and, if applicable, Part VIII or IX of this Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

Signature