

PRESIDENT:

Honorable Helen E. Freedman, J.S.C.

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF NEW YORK

----- X

IN RE: NEW YORK REZULIN PRODUCT LIABILITY      Index No. 752,000/00

----- X

THIS DOCUMENT APPLIES TO ALL REZULIN CASES  
IN THE SUPREME COURT OF THE STATE OF  
NEW YORK

CASE MANAGEMENT  
ORDER NO. 5  
December 7, 2000

**FILED**

DEC 27 2000

NEW YORK  
COUNTY CLERK'S OFFICE

----- X

**Adoption Of Plaintiff's Fact Sheet**

Pursuant to Case Management Order No. 3 entered in these coordinated cases on November 29, 2000, the Court-appointed committees of plaintiffs' and defendants' counsel have conferred to develop uniform discovery to be provided by the plaintiffs in these cases. Because of the complex nature of the medical issues in these coordinated cases and in consideration of the relatively limited number of cases expected to be included in this proceeding compared to the coordinated proceedings in this Court involving other pharmaceutical products and medical devices, this Court approved the use of a uniform set of interrogatories, document requests, bills of particulars and requests for authorizations, including requests for medical, employment and insurance authorizations and other pertinent documents, entitled Plaintiffs' Fact Sheet (the "Fact Sheet") that was jointly developed by the committees of plaintiffs' and defendants' counsel. The Court has reviewed the proposed Fact Sheet and all disputes as to the form and content of that Fact Sheet have been heard and ruled upon by this Court. Accordingly, it is hereby ORDERED, as follows:

1. **Adoption of Plaintiff's Fact Sheet.** The attached Plaintiff's Fact Sheet, including the attached List of Medical Providers and Other Sources of Information, is to be completed under oath by all plaintiffs, and the requested medical, employment and insurance authorizations and other pertinent documents are to be produced to defendants pursuant to the schedule and procedures previously Ordered in Case Management Order No. 3 entitled "Standard Consolidated Disclosure."

2. **Supplementation of Completed Fact Sheet.** The person completing the Fact Sheet shall have the duty and the right to supplement any response to the Fact Sheet if the party learns that any such response is incomplete or incorrect, or if new information responsive to the Fact Sheet becomes known to that party.

3. **Depositions of Plaintiffs.** Subject to the provisions of Case Management Order No. 3 and any further Orders of this Court regarding protocols to be observed in taking depositions, questions at the deposition of a plaintiff shall not seek mere repetition of information provided in that plaintiff's completed Fact Sheet. However, nothing in this Order shall prevent defendants from asking questions directed at correcting, supplementing, updating, explaining, expanding and/or generally confirming the information provided in a completed Fact Sheet to the extent permitted by the CPLR.

4. **Privilege Claims.** To the extent that any information, documents or authorizations required to be provided in response to the Fact Sheet are withheld on the grounds of privilege, a privilege log shall be provided of the information, documents or authorizations withheld.

5. **Depositions of the Children of Any Plaintiff.** No defendant shall subpoena the child of any plaintiff identified in a completed Fact Sheet without providing at least ten (10) days written Notice to the counsel of record for that plaintiff. If that plaintiff's counsel serves a written objection to that Notice, the provisions set forth in Case Management Order No. 3, paragraph E.8 shall apply.

6. **Redaction of Information.** To the extent that any information is redacted from any document for any reason, a redaction log of the redacted information that sets forth the legal basis for the redaction shall be provided to the defendants. If there is a dispute whether any redacted material qualifies for redaction, counsel may move for a ruling, which may require this Court's *in camera* inspection of the redacted material on the issue of whether that information is entitled to redaction.

7. **Validity of Authorizations.** All authorizations to obtain records provided pursuant to this Order, or any other Order of this Court, shall remain valid during the entire time that the action of the plaintiff who provided the authorization is pending in this Court, any transferor Court or any Court to which such action is remanded or transferred. No such authorization shall be valid after the action of the plaintiff who provided the authorization is concluded, either by settlement or by entry of final judgement. Nevertheless, any plaintiff may withdraw any authorization in writing if there is a good faith basis to conclude that such authorization has been or will be used to obtain records to which the defendants are not entitled in that case.

8. **Notification of Request for Records.** Whenever defendants request records pursuant to authorizations provided with the Fact Sheet, the principal attorney for that plaintiff,

as identified in Item I.A.5 of the completed Fact Sheet, shall be provided with a copy of that request for records.

**9. Copies of Records Received Pursuant to Authorization.** Whenever records are received by defendants in response to a request pursuant to authorizations provided with the Fact Sheet, a copy of those records shall be provided to the principal attorney for that plaintiff as identified in Item I.A.5. of the completed Fact Sheet.

**10. Documents Previously Produced by Defendants.** Nothing in this Order or the Fact Sheet shall be construed as requiring a plaintiff to produce copies of documents produced by the defendants in these coordinated proceedings or in other Rezulin litigation, if those documents were rightfully received by that plaintiff or by his or her counsel.

**11. Admissibility of Information Provided via Fact Sheet.** Neither this Order, nor the completion of a Fact Sheet and the required authorizations, shall prejudice the right of any party to contest the admissibility of any information or documents disclosed.

**12. Special Damages and Collateral Sources of Payment.** The rights of the defendants to obtain complete disclosure of special damages and of collateral source information pursuant to CPLR § 4545 is reserved, and each plaintiff is required to provide complete disclosure of special damages and of collateral source information at least sixty (60) days prior to filing a Note of Issue in his or her case.

13. This Order shall apply to all cases docketed in the New York Rezulin Product Liability Litigation and will remain in effect in all such cases after remand to transferor courts.

SO ORDERED

Dated: December 9, 2000  
New York, New York

*Helen E. Freedman*

Helen E. Freedman, J.S.C.

**FILED**

**DEC 27 2000**

**NEW YORK  
COUNTY CLERK'S OFFICE**

**IN RE NEW YORK REZULIN  
PRODUCTS LIABILITY LITIGATION  
MASTER INDEX NO. 752,000/00**

**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 the New York Rezulin Products Liability Litigation who has taken the diabetes drug Rezulin® or who is the representative of a person or the estate of a deceased person who took the diabetes drug Rezulin®.

If the response to any question is that the person completing this Fact Sheet does not know or does not recall the information requested, that response should be entered in the appropriate location(s).

**I. CASE INFORMATION**

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

1. Case Caption: \_\_\_\_\_

2. New York County Index No.: \_\_\_\_\_

3. Court in which action originally brought (transferor county):  
\_\_\_\_\_

4. Original Index number in the transferor court, if applicable.  
Index 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 a minor), please complete the following:

1. \_\_\_\_\_  
Your Name

2. \_\_\_\_\_  
Street Address

3. \_\_\_\_\_  
City, State and Zip Code

4. In what capacity are you representing the individual:  
\_\_\_\_\_

5. If you were appointed by a court, state the:  
\_\_\_\_\_

_____	_____
Court	Date of Appointment

6. Your relationship to deceased or represented person:  
\_\_\_\_\_

7. If you represent a decedent's estate, state the date of death of the decedent.  
\_\_\_\_\_

**[If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who took Rezulin®. Those questions using the term "You" refer to the person who took Rezulin®. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.]**

C. Claim Information

1. Do you claim that you have suffered a bodily injury as the result of Rezulin® use?

Yes \_\_\_\_\_ No \_\_\_\_\_

2. If the answer to the foregoing question is "Yes", state the nature of the injury or injuries which you claim.

---

---

---

3. If you do not claim you have suffered a bodily injury as the result of Rezulin® use, state how you have been injured.

---

---

---

**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, including the dates you used each name:

---

C. Address Information

1. Present Street Address:

\_\_\_\_\_  
Street Address                      City                      State      Zip Code

2. List all other addresses where you have lived for the last ten (10) years:

\_\_\_\_\_  
Street Address                      City                      State      Zip Code

\_\_\_\_\_  
Street Address                      City                      State      Zip Code



F. Date of Birth: \_\_\_\_\_

G. Place of Birth: \_\_\_\_\_

H. Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please state:

1. What branch and the dates of service. \_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, state what that condition was.

\_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, state what that condition was. \_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, 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]

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

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, 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]

M. 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.

\_\_\_\_\_  
\_\_\_\_\_

N. Have you been convicted of any felony or any crime of moral turpitude?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so:

1. What was the offense? \_\_\_\_\_
2. What was the date of conviction? \_\_\_\_\_
3. In what court was the conviction entered? \_\_\_\_\_

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

O. Education

Beginning with high school, complete the following information regarding educational institutions you have attended:

<u>Educational Institution</u>	<u>Dates Attended</u>	<u>Degrees/Certifications Received</u>

III. FAMILY INFORMATION

A. Are you currently married?

Yes \_\_\_\_\_ No \_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_

C. 1. Spouse's name: \_\_\_\_\_

2. Spouse's date of birth: \_\_\_\_\_

3. Spouse's occupation: \_\_\_\_\_

4. Spouse's current address: \_\_\_\_\_

D. Have you had any prior marriages?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, state the following:

Prior Spouse's Name: \_\_\_\_\_

Prior Spouse's Current Age: \_\_\_\_\_

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

E. Complete the following regarding your mother:

Mother's Name: \_\_\_\_\_

Mother's Age (or Age at Death): \_\_\_\_\_

F. Complete the following regarding your father:

Father's Name: \_\_\_\_\_

Father's Age (or Age at Death): \_\_\_\_\_

G. Do you have any sisters?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how many? \_\_\_\_\_

H. Do you have any brothers?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how many? \_\_\_\_\_

I. Do you have any children (whether by a current or prior marriage or relationship)?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, state the following:

Child's Name: \_\_\_\_\_

Child's Age (or Age at Death): \_\_\_\_\_

Does this child currently reside with you? Yes \_\_\_\_\_ No \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Age (or Age at Death): \_\_\_\_\_

Does this child currently reside with you? Yes \_\_\_\_\_ No \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Age (or Age at Death): \_\_\_\_\_

Does this child currently reside with you? Yes \_\_\_\_\_ No \_\_\_\_\_

[Attach additional sheets if necessary to describe more children]

J. To your knowledge, has any parent, grandparent or sibling been diagnosed with diabetes?

Yes \_\_\_\_\_ No \_\_\_\_\_ I don't know \_\_\_\_\_

If yes, identify each such person below and provide the information requested.

1. Name \_\_\_\_\_

Current Age (or Age at Death) \_\_\_\_\_

Type of Diabetes \_\_\_\_\_

If Applicable, Cause of Death \_\_\_\_\_

2. Name: \_\_\_\_\_

Current Age (or Age at Death): \_\_\_\_\_

Type of Diabetes: \_\_\_\_\_

If Applicable, Cause of Death: \_\_\_\_\_

3. Name: \_\_\_\_\_

Current Age (or Age at Death): \_\_\_\_\_

Type of Diabetes: \_\_\_\_\_

If Applicable, Cause of Death: \_\_\_\_\_

K. Has any parent, grandparent or sibling been diagnosed with liver disease?

Yes \_\_\_\_\_ No \_\_\_\_\_ I don't know \_\_\_\_\_

If yes, identify each such person below and provide the information requested.

1. Name: \_\_\_\_\_

Current Age (or Age at Death): \_\_\_\_\_

Type of Problem: \_\_\_\_\_

If Applicable, Cause of Death: \_\_\_\_\_

2. Name: \_\_\_\_\_

Current Age (or Age at Death): \_\_\_\_\_

Type of Problem: \_\_\_\_\_

If Applicable, Cause of Death: \_\_\_\_\_

3. Name: \_\_\_\_\_

Current Age (or Age at Death): \_\_\_\_\_

Type of Problem: \_\_\_\_\_

If Applicable, Cause of Death: \_\_\_\_\_

4. Name: \_\_\_\_\_

Current Age (or Age at Death): \_\_\_\_\_

Type of Problem: \_\_\_\_\_

If Applicable, Cause of Death: \_\_\_\_\_

**IV. DIABETIC CONDITION**

A. How old were you when you were first diagnosed with diabetes?

B. What type of diabetes were you diagnosed with?

\_\_\_\_\_ Type I or insulin dependent

\_\_\_\_\_ Type II or non-insulin dependent

C. By whom first diagnosed?

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

D. Which medications used to treat diabetes have you taken? (If you do not know or do not recall, please indicate in the appropriate column)

<u>Medication</u>		<u>Dosage</u>	<u>Date First Taken</u>	<u>Date Last Taken</u>
1. Sulfonylureas				
Yes ___ No ___ Don't Recall ___	Amaryl			
Yes ___ No ___ Don't Recall ___	DiaBeta			
Yes ___ No ___ Don't Recall ___	Diabinase			
Yes ___ No ___ Don't Recall ___	Dymelor			
Yes ___ No ___ Don't Recall ___	Glucotrol			
Yes ___ No ___ Don't Recall ___	Glucotrol XL			
Yes ___ No ___ Don't Recall ___	Glynase PresTab			
Yes ___ No ___ Don't Recall ___	Micronase			
Yes ___ No ___ Don't Recall ___	Orinase			
Yes ___ No ___ Don't Recall ___	Tolinase			
Yes ___ No ___ Don't Recall ___	Other (specify)			
2. Biguanides				
Yes ___ No ___ Don't Recall ___	Glucophage (Metformin)			
3. Alpha-glucosidase Inhibitors				
Yes ___ No ___ Don't Recall ___	Glyset			
Yes ___ No ___ Don't Recall ___	Precose			
4. Meglitinides				
Yes ___ No ___ Don't Recall ___	Prandin			
5. Insulin				
Yes ___ No ___ Don't Recall ___	Lispro (Humalog)			
Yes ___ No ___ Don't Recall ___	Regular			
Yes ___ No ___ Don't Recall ___	Premixed			

<u>Medication</u>		<u>Dosage</u>	<u>Date First Taken</u>	<u>Date Last Taken</u>
Yes __ No __ Don't Recall __	Ultralente			
Yes __ No __ Don't Recall __	NPH or Lente			
6. Glitazones				
Yes __ No __ Don't Recall __	Actos			
Yes __ No __ Don't Recall __	Avandia			
7. Other (specify)				
Yes __ No __ Don't Recall __				
Yes __ No __ Don't Recall __				

E. When did you take Rezulin®?

Date First Taken \_\_\_\_\_ Dosage \_\_\_\_\_  
Date Last Taken \_\_\_\_\_ Dosage \_\_\_\_\_

If there was a change in dosage, what was your understanding of the reason for the change?

\_\_\_\_\_

F. When you were taking Rezulin®, were you also taking any other diabetes medication(s)?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please identify the medications?

Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_

G. What were the last diabetic medications you were taking prior to beginning Rezulin®? (If you do not know or do not recall, please indicate.)

medication \_\_\_\_\_  
 dosage \_\_\_\_\_  
 dates taken \_\_\_\_\_

medication \_\_\_\_\_  
 dosage \_\_\_\_\_  
 dates taken \_\_\_\_\_

medication \_\_\_\_\_  
 dosage \_\_\_\_\_  
 dates taken \_\_\_\_\_

**V. MEDICAL BACKGROUND**

A. Height: \_\_\_\_\_

B. Current Weight: \_\_\_\_\_

C. Least Adult Weight: \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_.

D. Greatest Adult Weight: \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_.

E. Average Adult Weight: \_\_\_\_\_

F. To the best of your knowledge, have you ever taken any of the following medications? (If you do not know or do not recall, please indicate.)

<u>Medication</u>	<u>Dosage (or Don't Recall)</u>	<u>Date First Taken</u>	<u>Date Last Taken</u>	<u>Do Not Recall Date</u>
1. Tylenol Yes ___ No ___ Don't Recall ___				
2. Paracetamol Yes ___ No ___ Don't Recall ___				
3. Nyquil Yes ___ No ___ Don't Recall ___				

<u>Medication</u>	<u>Dosage (or Don't Recall)</u>	<u>Date First Taken</u>	<u>Date Last Taken</u>	<u>Do Not Recall Date</u>
4. Diclofenac (Voltaren) Yes __ No __ Don't Recall __				
5. Sulindac (Clinoril) Yes __ No __ Don't Recall __				
6. Aspirin Yes __ No __ Don't Recall __				
7. Ibuprofen (Advil, Motrin) Yes __ No __ Don't Recall __  If yes, specify _____				
8. Penicillin Yes __ No __ Don't Recall __				
9. Carbenicillin Yes __ No __ Don't Recall __				
10. Oxacillin Yes __ No __ Don't Recall __				
11. Amoxicillin Yes __ No __ Don't Recall __				
12. Erythromycin Yes __ No __ Don't Recall __				
13. Tetracyclines Yes __ No __ Don't Recall __				
14. Sulfonamides Yes __ No __ Don't Recall __  If yes, specify _____				
15. Antifungal agents Yes __ No __ Don't Recall __  If yes, specify _____				
16. Ketoconazole Yes __ No __ Don't Recall __				
17. Fluconazole Yes __ No __ Don't Recall __				

<u>Medication</u>	<u>Dosage (or Don't Recall)</u>	<u>Date First Taken</u>	<u>Date Last Taken</u>	<u>Do Not Recall Date</u>
18. Anti-TB drugs Yes __ No __ Don't Recall __  If yes, specify _____				
19. Rifampin Yes __ No __ Don't Recall __				
20. Isoniazid (INH) Yes __ No __ Don't Recall __				
21. Zidovudine Yes __ No __ Don't Recall __				
22. Didanosine Yes __ No __ Don't Recall __				
23. Fialuridine Yes __ No __ Don't Recall __				
24. Interferon alpha Yes __ No __ Don't Recall __				
25. Oral Contraceptives Yes __ No __ Don't Recall __  If yes, specify _____				
26. Estrogens Yes __ No __ Don't Recall __				
27. Anabolic steroids Yes __ No __ Don't Recall __  If yes, specify _____				
28. Androgenic steroids Yes __ No __ Don't Recall __  If yes, specify _____				
29. Flutar Yes __ No __ Don't Recall __				
30. Hormones Yes __ No __ Don't Recall __  If yes, specify _____				

<u>Medication</u>	<u>Dosage (or Don't Recall)</u>	<u>Date First Taken</u>	<u>Date Last Taken</u>	<u>Do Not Recall Date</u>
31. Niacin Yes ___ No ___ Don't Recall ___				
32. HMG COA reductase inhibitors Yes ___ No ___ Don't Recall ___				
33. Halothane (anesthetic) Yes ___ No ___ Don't Recall ___				
34. Chlorpromazine (Thorazine) Yes ___ No ___ Don't Recall ___				
35. Carbamazepine (Tegretol) Yes ___ No ___ Don't Recall ___				
36. Phenytoin (Dilantin) Yes ___ No ___ Don't Recall ___				
37. Valproic acid (DepaKene) Yes ___ No ___ Don't Recall ___				
38. Antidepressants Yes ___ No ___ Don't Recall ___ If yes, specify _____				
39. Antipsychotics Yes ___ No ___ Don't Recall ___ If yes, specify _____				
40. Amiodarone Yes ___ No ___ Don't Recall ___				
41. Alpha-methyldopa (Aldomet) Yes ___ No ___ Don't Recall ___				
42. ACE inhibitors Yes ___ No ___ Don't Recall ___ If yes, specify _____				

Medication	Dosage (or Don't Recall)	Date First Taken	Date Last Taken	Do Not Recall Date
43. Calcium channel blockers Yes ___ No ___ Don't Recall ___  If yes, specify _____				
44. Methotrexate Yes ___ No ___ Don't Recall ___				
45. 5-Fluorouracil (5-FU) Yes ___ No ___ Don't Recall ___				
46. Azathioprine Yes ___ No ___ Don't Recall ___				
47. Cyclosporine Yes ___ No ___ Don't Recall ___				
48. Chemotherapeutic agents Yes ___ No ___ Don't Recall ___  If yes, specify _____				
49. Immunosuppressive agents Yes ___ No ___ Don't Recall ___  If yes, specify _____				
50. Vicodin Yes ___ No ___ Don't Recall ___				
51. Duract Yes ___ No ___ Don't Recall ___				
52. Tagamet Yes ___ No ___ Don't Recall ___				
53. Entex Yes ___ No ___ Don't Recall ___				
54. Vibramycin Yes ___ No ___ Don't Recall ___				
55. Darvocet Yes ___ No ___ Don't Recall ___				
56. Excedrin Yes ___ No ___ Don't Recall ___				

<u>Medication</u>	<u>Dosage (or Don't Recall)</u>	<u>Date First Taken</u>	<u>Date Last Taken</u>	<u>Do Not Recall Date</u>
57. Vancenase Yes ___ No ___ Don't Recall ___				
58. Allergy medications or remedies Yes ___ No ___ Don't Recall ___ If yes, specify _____				
59. Herbal preparations or remedies Yes ___ No ___ Don't Recall ___ If yes, specify _____				

60. List any other prescription medications taken by you from five (5) years before the onset of your diabetes until today:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

G. For any of the medications you indicated you have taken in subpart F, did you experience any adverse reaction associated with that medication?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so:

Describe the reaction: \_\_\_\_\_

Provide approximate date of reaction: \_\_\_\_\_

Did you discontinue use of this medication?: \_\_\_\_\_

H. To the best of your knowledge, have you used, ingested or been exposed to during the course of your employment to the following:

			Don't Know	Don't Recall	Dates of Use, Ingestion or Exposure
insecticides, e.g. DDT	Yes __	No __	___	___	_____
floorwax	Yes __	No __	___	___	_____
cleaning supplies	Yes __	No __	___	___	_____
dry cleaning chemicals	Yes __	No __	___	___	_____
hazardous waste material	Yes __	No __	___	___	_____
vinyl chloride	Yes __	No __	___	___	_____
carbon tetrachloride (Fire extinguishers, solvents, fumigants)	Yes __	No __	___	___	_____
benzene	Yes __	No __	___	___	_____
chlorinated hydrocarbons	Yes __	No __	___	___	_____
arsenic (dyes, paint, petroleum, ceramics, semiconductors)	Yes __	No __	___	___	_____
aflatoxin (nuts, corn, wheat, barley, soybeans)	Yes __	No __	___	___	_____
amanita mushroom poisoning	Yes __	No __	___	___	_____

To the best of your knowledge, state which of the following tests/studies you have undergone.

		Yes	No	Don't Know	Don't Recall	Last name of Doctor
1.	Radiographic studies (i.e., x-ray)	___	___	___	___	
2.	Sonographic studies (i.e., liver sonogram)	___	___	___	___	
3.	Biopsy (i.e., liver/kidney)	___	___	___	___	
4.	Liver Transplant	___	___	___	___	
5.	Liver function studies	___	___	___	___	
6.	Electrocardiogram	___	___	___	___	
7.	Echocardiogram	___	___	___	___	
8.	Cardiac or pulmonary artery catheterization	___	___	___	___	
9.	Pulmonary function test	___	___	___	___	
11.	Blood studies (i.e., liver enzymes)	___	___	___	___	
12.	Other (specify)	___	___	___	___	

13. If you are completing this Fact Sheet as the representative of a deceased person, what was the date of death? \_\_\_\_\_

Was an autopsy performed? \_\_\_\_\_

If yes, at which facility? \_\_\_\_\_

\_\_\_\_\_  
Name of Facility

\_\_\_\_\_  
Address

I. Smoking history [check whichever is applicable]

1. never smoked 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

J. Drinking history

1. Have you ever been told that you have a problem with alcohol abuse?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, by whom? \_\_\_\_\_

K. To the best of your knowledge, have you ever been told by a doctor or any other person, that you have, may have, or had any of the following:

		Yes	No	Don't Know	Don't Recall	Last name of Doctor
1.	Hyperglycemia (elevated blood sugar)	___	___	___	___	
2.	Hyperinsulinemia	___	___	___	___	
3.	Nephropathy (kidney disease)	___	___	___	___	
4.	Retinopathy	___	___	___	___	
5.	Glaucoma	___	___	___	___	
6.	Vascular disease	___	___	___	___	
7.	Autoimmune disease	___	___	___	___	
8.	Systemic lupus erythematosus (SLE)	___	___	___	___	
9.	Scleroderma (systemic sclerosis)	___	___	___	___	
10.	Rheumatoid arthritis	___	___	___	___	
11.	Cancer	___	___	___	___	
12.	Leukemia	___	___	___	___	

		Yes	No	Don't Know	Don't Recall	Last name of Doctor
13.	Lymphoma/Hodgkin's disease	___	___	___	___	
14.	Liver disease	___	___	___	___	
15.	Dark urine	___	___	___	___	
16.	Jaundice	___	___	___	___	
17.	Liver enzyme abnormalities	___	___	___	___	
18.	Hypothyroidism	___	___	___	___	
19.	Hyperthyroidism	___	___	___	___	
20.	Wilson's disease	___	___	___	___	
21.	Hemochromatosis	___	___	___	___	
22.	Bacterial infections	___	___	___	___	
23.	Spirochetal infections	___	___	___	___	
24.	Parasitic disease	___	___	___	___	
25.	Fungal liver disease	___	___	___	___	
26.	Liver abscesses, cysts or tumors	___	___	___	___	
27.	Tuberculosis	___	___	___	___	
28.	Sarcoidosis	___	___	___	___	
29.	Crohn's disease	___	___	___	___	
30.	HIV and associated viral infections	___	___	___	___	
31.	Amyloidosis	___	___	___	___	
32.	Cardiac/Heart disease	___	___	___	___	
33.	Nephrogenic liver dysfunction	___	___	___	___	
34.	Collagen vascular diseases	___	___	___	___	
35.	Hematologic disease	___	___	___	___	
36.	Niemann-Pick disorder	___	___	___	___	

		Yes	No	Don't Know	Don't Recall	Last name of Doctor
37.	Wolman's disease	___	___	___	___	
38.	Tangier disease	___	___	___	___	
39.	Metabolic disorders	___	___	___	___	
40.	Antitrypsin deficiency	___	___	___	___	
41.	Tyrosinemia	___	___	___	___	
42.	Galactosemia	___	___	___	___	
43.	Reyes syndrome	___	___	___	___	
44.	Ischemic hepatic injury associated w/heart disease	___	___	___	___	
45.	Hepatitis A	___	___	___	___	
46.	Hepatitis B	___	___	___	___	
47.	Hepatitis C	___	___	___	___	
48.	Nonalcoholic steatohepatitis or fatty liver (NASH)	___	___	___	___	
49.	Hepatic vein occlusion (Budd Chiari Syndrome)	___	___	___	___	
50.	Autoimmune hepatitis	___	___	___	___	
51.	Acute fatty liver of pregnancy (if female)	___	___	___	___	
52.	Drug or toxin induced hepatitis	___	___	___	___	
53.	Substance abuse	___	___	___	___	
54.	Alcohol abuse	___	___	___	___	
55.	Cirrhosis of the liver	___	___	___	___	
56.	Gallbladder disease	___	___	___	___	
57.	Obesity	___	___	___	___	
58.	Shortness of breath	___	___	___	___	
59.	Hypertension	___	___	___	___	
60.	Angina (chest pain)	___	___	___	___	

		Yes	No	Don't Know	Don't Recall	Last name of Doctor
61.	Atherosclerosis	___	___	___	___	
62.	Arteriosclerosis (hardening of the arteries)	___	___	___	___	
63.	Myocardial infarction (heart attack)	___	___	___	___	
64.	Congestive heart failure (CHF)	___	___	___	___	
65.	Pulmonary/lung disorders	___	___	___	___	
66.	Emphysema	___	___	___	___	
67.	Asthma	___	___	___	___	

L. If you claim psychological or emotional injury as a consequence of Rezulin® use, have you experienced or been treated for any psychological, psychiatric or emotional problem prior to the use of Rezulin®?

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

---

**VI. MISCELLANEOUS**

A. 1. Have you had discussions with any doctor about whether your condition is related to Rezulin®?

Yes \_\_\_\_\_ No \_\_\_\_\_ I don't recall \_\_\_\_\_

2. If yes, what, if anything, did he tell you?

---

---

---

---

3. Identify the doctor or doctors

---

Name

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

B. Were you given any written instructions or warnings regarding Rezulin®?

Yes \_\_\_\_\_ No \_\_\_\_\_ Do not recall \_\_\_\_\_

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)

If yes, state what those warnings or instructions were.

---

C. Were you given any oral instructions or warnings regarding Rezulin®?

Yes \_\_\_\_\_ No \_\_\_\_\_ Do not recall \_\_\_\_\_

If yes, state when the oral 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)

If yes, state what those warnings or instructions were.

---

D. 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 Rezulin®:

1. Complete the following information with respect to your employment for the past ten (10) years.

<u>Employers for Past Ten (10) Years</u>	<u>Address</u>	<u>Type of Business/Position</u>	<u>Dates of Employment</u>

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 Rezulin® and your personal understanding of the amount of income which you lost.

---

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

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

E. 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 Rezulin® and for which you seek recovery in the action which you have filed?

Yes \_\_\_\_\_ No \_\_\_\_\_

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

F. Complete the information below for any person who has knowledge of information concerning your use of Rezulin® and the injuries you claim from that use.

<u>Person's Name and Address</u>	<u>Relationship to You</u>	<u>Any Documents You Know Are Possessed By This Person</u>

[Attach additional sheets if necessary to describe more persons]

G. Clinical Studies

Have you ever participated in a Rezulin® clinical study trial?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what was the name of the study?

---

---

What was the date you enrolled in the study? \_\_\_\_\_

To which health care facility did you report?

---

Facility

---

Address

To whom did you report?

---

Name of health care professional.

---

Address

**IN RE NEW YORK REZULIN  
PRODUCTS LIABILITY LITIGATION**  
Master Index No. 752,000/00

**LIST OF MEDICAL PROVIDERS  
AND OTHER SOURCES OF INFORMATION**

EACH PLAINTIFF IN THE NEW YORK REZULIN PRODUCTS LIABILITY LITIGATION WHO IS REQUIRED TO COMPLETE A DECLARATION MUST FULLY AND ACCURATELY COMPLETE THIS FORM LISTING MEDICAL CARE PROVIDERS AND OTHER SOURCES OF INFORMATION AS REQUESTED.

List the name and address of each of the following:

**A. Your current family physician:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

**B. To the best of your ability, identify each of your primary care physicians for the period beginning five (5) years before the onset of your diabetes to date:**

1. \_\_\_\_\_  
Name Approximate dates

\_\_\_\_\_  
Last known address

\_\_\_\_\_  
City, State, Zip Code

2. \_\_\_\_\_  
Name Approximate dates

\_\_\_\_\_  
Last known address

\_\_\_\_\_  
City, State, Zip Code

3. \_\_\_\_\_  
Name Approximate dates

\_\_\_\_\_  
Last known address

\_\_\_\_\_  
City, State, Zip Code

4. \_\_\_\_\_  
Name Approximate dates  
\_\_\_\_\_  
Last known address  
\_\_\_\_\_  
City, State, Zip Code

C. Each **endocrinologist, cardiologist, pulmonary physician** and/or **liver** and/or **diabetes specialist** who has ever seen or treated you.

1. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

2. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

3. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

4. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

D. Each **hospital** where you have received **inpatient** treatment during the period beginning five (5) years before the onset of your diabetes to date (excluding treatment for psychological, psychiatric or emotional problems unless you claim psychological or emotional injury as a consequence of your use of Rezulin®):

1. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

2. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

3. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

E. Each **hospital or healthcare facility** where you have received **outpatient** treatment (including treatment in an emergency room) during the period beginning five (5) years before the onset of your diabetes to date (excluding treatment for psychological, psychiatric or emotional problems unless you claim psychological or emotional injury as a consequence of your use of Rezulin®):

1. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

2. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

3. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

4. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

5. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

F. Each other **physician** or **healthcare provider** from whom you have received treatment in the period beginning five (5) years before the onset of your diabetes to date (excluding treatment for psychological, psychiatric or emotional problems unless you claim psychological or emotional injury as a consequence of your use of Rezulin®):

1. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code
2. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code
3. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code
4. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code
5. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

6. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

7. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

8. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

9. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

10. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

G. Each **pharmacy, drugstore** and the like where you have had prescriptions filled during the period beginning five (5) years before the onset of your diabetes to date or from which you have ever received any prescription medication taken to control your diabetes.

1. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

2. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

3. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

4. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

5. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

H. **If but only if** you claim that you suffered psychological or emotional injuries as a result of taking Rezulin®, list each **psychiatrist, psychologist and/or social worker** from whom you have received treatment since you were first diagnosed with diabetes.

1. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

2. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

3. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

- I. If you have submitted a claim **for social security disability benefits** in the last twenty years, state the name and address of the office which is most likely to have records concerning your claim.

\_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

- J. If you have submitted a claim for **workers compensation**, state the name and address of the office which is most likely to have records concerning your claim.

\_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code

- K. Do you currently have **private health insurance**?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, provide the following:

\_\_\_\_\_  
Name of Health Insurance Company

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

Identify all other health insurance you have or have had for the period beginning five (5) years before the onset of your diabetes to date (either on an individual basis or as a member of an insured family, including group coverage and coverage under policies of insurance issued to or on behalf of parents and/or spouses).

\_\_\_\_\_  
Name of Health Insurance Company

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Dates of Coverage

\_\_\_\_\_  
Name of Health Insurance Company

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Dates of Coverage

Have you ever been denied health insurance?

Yes \_\_\_\_\_

No \_\_\_\_\_

If so, identify the following:

Name of company which denied coverage: \_\_\_\_\_

Reason(s) coverage was denied: \_\_\_\_\_

Date(s) on which coverage denied: \_\_\_\_\_

**[ATTACH ADDITIONAL SHEETS, IF  
NECESSARY, TO COMPLETE EACH SUBSECTION]**

**DECLARATION**

I declare under penalty of perjury that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, information and belief, and that I have supplied the authorizations attached to this declaration.

\_\_\_\_\_  
Signature

Sworn to before me this

\_\_\_\_ day of \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

IN THE SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF NEW YORK

IN RE NEW YORK REZULIN :  
PRODUCTS LIABILITY LITIGATION : Master Index No. 752,000/00

**DEMAND FOR  
DOCUMENTS AND AUTHORIZATIONS**

Plaintiffs and plaintiffs' counsel must produce the following documents to the extent that such documents are currently in their possession, custody and control, and must provide original signed authorizations for same, including the release of records in the form appended hereto for each physician, hospital, health care provider, pharmacy, health insurer, employer and other source of information identified in this Fact Sheet and in the List of Medical Providers and Other Sources of Information.

- A. A copy of all medical records from any physician, hospital, health care provider or other entity that is set forth in the attached List of Medical Providers and Other Sources of Information, including, but not limited to, a copy of all prescriptions, receipts, physician or office records, drug containers, packaging and other records which show each diabetic medication you have taken, the period during which you have taken each, the dosage of each diabetic medication and the frequency with which you took each medication, as well as all billings, correspondence, lab and culture reports, reports, surgical records, x-rays, MRIs, biopsies, transplants, cardiac, renal and pulmonary studies, and all medical prescriptions related thereto.
- B. If you claim any loss from medical expenses, copies of all bills, invoices, or other writings that refer to, relate to, or reflect your medical treatment and care and/or any other damages that you claim in connection with this action, including, but not limited to, doctor and hospital bills, prescription bills, medical equipment, nursing services, therapy and counseling, and other employed help.
- C. All documents in your possession, custody or control that refer or relate to any communication (whether written or oral) between you, or any person on your behalf, and the Warner-Lambert Company and/or its unincorporated Parke-Davis division, including without limitation any notes, correspondence or recordings of any such communication.
- D. All documents in your possession, custody or control that refer or relate to any communication (whether written or oral) between you, or any person on your behalf, and any of your health care providers concerning diabetes, Rezulin®, or any act, omission or conduct by any defendant in this action, including without limitation any notes, correspondence or recording of such communication.
- E. All documents that refer or relate to any clinical studies, tests or trials in which you participated.

- F. All diaries, chronicles or journals you have kept, maintained or written in, during the period from the date of onset of your diabetes to the present that record events related to your diabetes, your use of medications to treat or control your diabetes or any injury claimed in this action. (Information contained in diaries, chronicles or journals that is not responsive to this request may be redacted under the procedures set forth in the Order adopting this Fact Sheet.)
- G. If you claim or expect to claim that you lost earnings or earning capacity as a result of any condition which you believe was caused by your use of Rezulin®, all documents that refer or relate to any and all employment or self-employment records for each instance of your employment or self-employment in the past ten (10) years, including but not limited to the following:
1. All W-2 and 1099 forms, and if you were self-employed with respect to any of your income, all federal and state tax returns, including all schedules and attachments thereto;
  2. All documents that refer or relate to any termination of employment;
  3. All documents that refer or relate to any job reviews or evaluations and/or performance appraisals;
  4. Each health questionnaire and each document that refers or relates to the results of any medical examinations or treatments for any such employment or self-employment; and
  5. All written applications for employment that you have made.
- H. All documents, including, but not limited to, hearing transcripts, orders and directives, that refer or relate to any disability benefits of any sort that you applied for and/or received and/or any disability proceeding of any sort to which you were a party, including, without limitation, all documents that refer or relate to any of the following benefits applied for, received by, or denied to you: medical insurance benefits; worker's compensation benefits; sickness, accident or disability benefits provided or through an employer for nonemployment related conditions; Social Security disability benefits; veterans' medical disability benefits; union disability benefits; or any other disability benefits.
- I. Except to the extent that such documents have been prepared by experts or potential experts, all medical photographs, x-rays, medical motion pictures, medical videotapes, medical drawings, or other medical visual reproductions of any type depicting the alleged injuries and damages described in your Complaint.
- J. All documents in your possession, custody or control containing instructions, warnings, and other writings that you, or any person acting on your behalf, received from any health care provider who prescribed Rezulin® or any other diabetes drugs or agents for you.

- K. All documents (including, but not limited to, all letters, written statements, advertisements and memoranda) published, generated, or distributed by Warner-Lambert or any of its agents, servants, or employees, including but not limited to, all documents that you, or any person acting on your behalf, received or obtained, directly or indirectly, from Warner-Lambert that refer or relate to Rezulin®.
- L. All other documents that refer to, relate to, or support any damage you claim to have sustained as a result of your ingestion of Rezulin® and/or any act, omission or conduct by the Warner-Lambert Company.
- M. If you claim to have suffered psychological or emotional injury as a result of taking Rezulin®, all documents that refer or relate to your physical and/or psychological health, including but not limited to any anxiety, worry or emotional distress you believe you have experienced, whether or not in relation to the alleged injuries claimed in your complaint.

IN THE SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF NEW YORK

IN RE NEW YORK REZULIN :  
PRODUCTS LIABILITY LITIGATION : Master Index No. 752,000/00

**AUTHORIZATION**  
**(No Psychological Injury Claimed)**

To: \_\_\_\_\_  
Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City, State and Zip Code

This will authorize you to furnish copies of all medical records, reports, radiographic films, prescription records, echocardiographic recordings, written statements, employment records, wage records, disability records, medical bills, and other documents in your possession **except for records of treatment for psychological, psychiatric or emotional problems,** concerning \_\_\_\_\_

\_\_\_\_\_  
Name of Patient

whose date of birth is \_\_\_\_\_ and whose social security number is \_\_\_\_\_.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who has agreed to pay reasonable charges made by you to supply copies of such records.

\_\_\_\_\_  
Name of Representative

\_\_\_\_\_  
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient, Guardian or  
Authorized Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
Witness Signature

IN THE SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF NEW YORK

IN RE NEW YORK REZULIN :  
PRODUCTS LIABILITY LITIGATION : Master Index No. 752,000/00

**AUTHORIZATION**  
**(Psychological Injury is Claimed)**

To: \_\_\_\_\_  
Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City, State and Zip Code

This will authorize you to furnish copies of all medical records, reports, radiographic films, prescription records, echocardiographic recordings, written statements, employment records, wage records, disability records, medical bills, and other documents in your possession concerning \_\_\_\_\_

Name of Patient

whose date of birth is \_\_\_\_\_ and whose social security number is \_\_\_\_\_.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who has agreed to pay reasonable charges made by you to supply copies of such records.

\_\_\_\_\_  
Name of Representative

\_\_\_\_\_  
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgment at the bottom of this authorization.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient, Guardian or  
Authorized Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
Witness Signature

IN THE SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF NEW YORK

IN RE NEW YORK REZULIN :  
PRODUCTS LIABILITY LITIGATION : Master Index No. 752,000/00

**EMPLOYMENT AUTHORIZATION**

To: \_\_\_\_\_  
Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City, State and Zip Code

This will authorize you to furnish copies of all written applications for employment, all employment records, wage records, W-2 and 1099 forms, all documents that refer or relate to any job reviews or evaluations and/or performance appraisals, all documents that refer or relate to any termination of employment, disability records, each health questionnaire and each document that refers or relates to the results of any medical examinations or treatments for any such employment, medical bills, written statements and other documents in your possession concerning \_\_\_\_\_

Name of Employee

whose date of birth is \_\_\_\_\_ and whose social security number is \_\_\_\_\_

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who has agreed to pay reasonable charges made by you to supply copies of such records.

\_\_\_\_\_  
Name of Representative

\_\_\_\_\_  
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Employee, Guardian or  
Authorized Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
Witness Signature