IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

MDL No. 3081
In Re Bard Implanted Port Catheter Products Liability Litigation

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PLAINTIFF FACT SHEET

Each plaintiff, or representative of a person, who allegedly suffered injury/injuries as a result of a Bard Implanted Port Catheter(s) who also is included in the PFS/DFS Group 1 as established in Case Management Order No. 10 [Dkt. No. 115] must complete the following Plaintiff Fact Sheet ("Plaintiff Fact Sheet"). In completing this Fact Sheet, You are **under oath and must answer every question.** You must provide information that is true and correct to the best of Your knowledge. If You cannot recall all of the details as requested, provide as much information as You can and then state that Your answer is incomplete and explain why, as appropriate. If you select an "I Don't Know" answer, please state all that You do know about that subject. If any information You need to complete any part of the Fact Sheet is in the possession of your attorney, please consult with Your attorney so that You can fully and accurately respond to the questions set out below. If You are completing the Fact Sheet for someone who cannot complete the Fact Sheet for himself/herself, please answer as completely as You can.

Each Plaintiff Fact Sheet shall be signed by the Plaintiff under penalty of perjury at the time of submission. If a Plaintiff is suing in a representative capacity, the Plaintiff Fact Sheet shall be completed and signed by the person with legal authority to represent the estate or the person under legal disability. A Plaintiff's spouse with a claim for loss of consortium shall also sign the Plaintiff Fact Sheet under penalty of perjury. **Electronic signatures are not permitted.**

The Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. A completed Fact Sheet shall be considered interrogatory answers pursuant to Fed. R. Civ. P. 33 and responses to requests for production pursuant to Fed. R. Civ. P. 34 and will be governed by the standards applicable to written discovery under Fed. R. Civ. P. 26 through 37. Therefore, You must promptly supplement Your responses and document production if You learn that they are incomplete or incorrect in any material respect. The questions and requests for production of documents contained in this Fact Sheet are non-objectionable and shall be answered without objection. This Fact Sheet shall not preclude Bard Defendants from seeking additional documents and information on a reasonable, case-by-case basis, pursuant to the Federal Rules of Civil Procedure and as permitted by the applicable Case Management Order.

In filling out this form, the terms "You" or "Your" refer to the person who received a Bard Implanted Port Catheter Product(s) manufactured and/or distributed by Bard Access Systems, Inc.; C. R. Bard, Inc.; Bard Peripheral Vascular, Inc.; or Becton, Dickinson and Company ("Bard Defendants") and who is identified in Question 2(a) below.

In filling out this form, "healthcare provider" shall mean any medical provider, doctor, physician, surgeon, pharmacist, hospital, clinic, medical center, physician's office, infirmary, medical/diagnostic laboratory, or any other facility that provides medical care or advice, along with any pharmacy, x-ray department, radiology department, laboratory, physical therapist/physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in Your diagnosis, care and/or treatment.

Information provided by Plaintiff will only be used for the purposes related to this litigation and may be disclosed only as permitted under the protective order in this litigation.

The fully completed Fact Sheet and all documents requested should be uploaded to MDL Centrality online system at www.mdlcentrality.com/BardPort.

I. BACKGROUND INFORMATION

1. Verify that the Plaintiff Profile Form previously served by Plaintiff is complete and accurate, including production of all records requested, as of the date of completion of this Plaintiff Fact Sheet. If the Plaintiff Profile Form previously served by Plaintiff is not complete and accurate as of the date of completion of this Plaintiff Fact Sheet, update and attach an Amended or Supplemental Plaintiff Profile Form.

☐ I verify that the Plaintiff Profile Form served on _____ is complete and accurate as of the date of completion of this Plaintiff Fact Sheet.

☐ An updated Plaintiff Profile Form is attached.

2. Please state:

(a) Your full name:

_____

(b) Full name of the person completing this form, if different from the person listed in 2(a) above:

_____

(c) Relationship of the person completing this form to the person listed in 2(a) above:

_____

(d) When did the person completing this form first retain an attorney for this lawsuit against the Bard Defendants?

_____

3. Your Social Security Number: _____

4. If You have lived at Your current address as set forth in Your Profile Form for less than 10 years, provide each of Your prior residential addresses from 2000 to the present. Specifically identify the address where you lived when your Bard Implanted Port Cather Product(s) was/were implanted:

Prior Residential Address	Dates You Lived At This Address
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present

5. Have You ever been married? Yes/No:_____

If yes, provide the names and addresses of each spouse and the inclusive dates of Your marriage to each person:

Full name of spouse	Dates of marriage and how marriage ended

6. Do You have children? Yes/No:_____

If Yes, please provide the following information with respect to each child:

Full Name of Child	Date of Birth	Home Address	Whether Biological/Adopted
		Street: City: State: Zip:	
		Street: City: State: Zip:	
		Street: City: State: Zip:	
		Street: City: State: Zip:	
		Street: City: State: Zip:	
		Street: City: State: Zip:	
		Street: City: State: Zip:	

7. Identify the name and age of any person who currently resides with You and their relationship to You:

Name	Date of Birth	Relationship

8. Identify the name and age of any person who has resided with You at any point over the past ten (10) years:

Name	Date of Birth/Age	Relationship

9. If Your Implanted Port Catheter Product(s) was/were implanted more than ten (10) years ago, identify the name and age of any person who lived with You when the Implanted Port Catheter Product(s) was/were implanted.

Name	Date of Birth/Age	Relationship

10. Identify all secondary and post-secondary schools You attended, starting with high school, and please provide the following information with respect to each:

Name of School	Address	Dates of Attendance	Degree Awarded	Major or Primary Field of Study
	Street: City: State: Zip:	to ☐ Present		
	Street: City: State: Zip:	to ☐ Present		
	Street: City: State: Zip:	to ☐ Present		
	Street: City: State: Zip:	to ☐ Present		
	Street: City: State: Zip:	to ☐ Present		
	Street: City: State: Zip:	to ☐ Present		

11. Please provide the following information for Your employment history over the past 10 years through the present:

Employer Name	Address	Job Title/Description of Duties	Dates of Employment	Salary/Rate of Pay
	Street: City: State: Zip:		to ☐ Present	
	Street: City: State: Zip:		to ☐ Present	
	Street: City: State: Zip:		to ☐ Present	
	Street: City: State: Zip:		to ☐ Present	
	Street: City: State: Zip:		to ☐ Present	

12. If Your Implanted Port Catheter Product(s) was/were implanted more than ten (10) years ago, provide the following information for Your employer at the time of implant:

Port and Implant Date	Employer Name	Address	Job Title/ Description of Duties	Dates of Employment	Salary/Rate of Pay
		Street: City: State: Zip:		to ☐ Present	
		Street: City: State: Zip:		to ☐ Present	
		Street: City: State: Zip:		to ☐ Present	
		Street: City: State: Zip:		to ☐ Present	

13. Have You ever served in any branch of the military? Yes/No:_____

If Yes, please provide the following information:

(a) Branch:

_____

(b) Dates of service: _____

(c) Rank upon discharge: _____

(d) Type of discharge received: _____

(e) Were You discharged from the military at any time for any reason relating to Your medical, physical, or psychiatric condition? Yes/No:_____

If Yes, state what that condition was:

_____

14. Within the last ten years, have You been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty? Yes/No:_____

If Yes, please set forth where and when and identify the felony and/or crime:

_____

15. Identify all television, electronic, social media or print advertisements regarding possible claims against implanted port catheter product manufacturers that You or Plaintiff saw before you filed this lawsuit:

16. For the advertisements identified immediately above, set forth the approximate date and nature of any such advertisement, whether the advertisement included the name of a law firm, and whether the advertisement specifically mentioned Bard Access Systems; C. R. Bard, Inc.; Bard Peripheral Vascular, Inc.; Becton, Dickinson and Company; or "Bard".

17. Have You received any telephone calls, emails, letters, or text messages ("Communications") regarding possible claims against Implanted Port Catheter Product manufacturers, including but not limited to Bard Access Systems; C. R. Bard, Inc.; Bard Peripheral Vascular, Inc.; Becton, Dickinson and Company; or "Bard"? This is not intended to apply to any communications with your attorney.

Yes/No:_____

18. For the Communications identified immediately above, set forth the approximate date and nature that You received each and every communication, whether the Communication included the name of a law firm, and whether the Communication specifically mentioned Bard Access Systems; C. R. Bard, Inc.; Bard Peripheral Vascular, Inc.; Becton, Dickinson and Company; or "Bard". This is not intended to apply to any communications with your attorney after you retained him/her.

II. CLAIM INFORMATION

IF YOU ARE MAKING A CLAIM IN THIS LAWSUIT ALLEGING DAMAGES AND/OR INJURIES ARISING FROM THE IMPLANTATION OF MORE THAN ONE BARD IMPLANTED PORT CATHETER PRODUCT ("PRODUCT"), YOU MUST FILL OUT SECTION II "CLAIM INFORMATION" IN ITS ENTIRETY FOR EACH SUCH PRODUCT.

19. Date of implant: _____

Lot number: _____

Product Code: _____

Model name: _____

Date of last treatment/access of the Product: _____

Date of removal: _____

20. Describe Your understanding of Your medical condition at the time You received the Bard Implanted Port Catheter Product and why You received the product:

_____

21. For each failure mode alleged in Section 4 of Your Profile Form state the following:
The date you first believed that the complication was related to Your Bard Implanted Port Catheter Product and how you came to that belief. If the aforesaid belief was based on the statement(s) of another individual, specifically identify the individual who made such statement(s) and provide that persons or people's full name(s) and address and the date the communication was made.

_____

22. Describe any written and/or verbal information or instructions regarding the Bard Implanted Port Catheter Product that You received:

_____

23. For the information or instructions regarding the Bard Implanted Port Catheter Product that You received:

(a) Provide the date You received the written and/or verbal information or instructions:

_____

(b) Identify by name and address the person(s) who provided the information and instructions:

_____

(c) What information or instructions did You receive?

_____

(d) If You have copies of the written information or instructions You received, please upload copies to MDL Centrality.

_____

(e) Were You told of any potential complications associated with the implant of a Bard Implanted Port Catheter Product? Yes/No/Don't Know:_____

(f) If yes to (e), by whom?

_____

(g) If yes to (e), what potential complications were described to You?

_____

24. Do You claim that You suffered bodily injuries as a result of the implantation of the Bard Implanted Port Catheter Product?

Yes/No:_____

If Yes:

(a) To the best of Your knowledge and recollection, has any health care provider ever told You orally or in writing that any symptoms related to bodily injury are related to the Bard Implanted Port Catheter Product?

Yes/No:_____

If Yes, please state the name and address of any such health care provider, as well as provide the approximate date the statement was made, and provide the details of the communication:

(b) Are You currently experiencing symptoms related to Your claimed bodily injuries?

Yes/No:_____

If Yes, please describe Your symptoms in detail:

(c) When was the first time You experienced symptoms of any of the bodily injuries You claim in Your lawsuit to have resulted from the Bard Implanted Port Catheter Product?

(d) Are You currently seeing, or have You ever seen, a doctor or healthcare provider for any of the bodily injuries or symptoms listed above?

Yes/No:_____

If Yes, please list in chronological order of treatment all doctors or healthcare providers You have seen for treatment of any of the bodily injuries You have listed above.

Provider Name and Address	Condition Treated	Approximate Dates of Treatment
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		

Provider Name and Address	Condition Treated	Approximate Dates of Treatment
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		

(e) Were You hospitalized at any time for the bodily injuries You listed above?

Yes/No:_____

If Yes, please provide the following:

Hospital Name and Address	Condition Treated	Approximate Dates of Treatment
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		
Name: Street: City: State: Zip:		

(f) Identify by name and address the doctor(s), nurse(s), hospital(s), or other healthcare provider(s) who accessed your Bard Implanted Port Catheter Product and provide the approximate date(s) for each such occurrence:

Approximate Date(s)/Date Range(s)	Doctor or Healthcare Provider Involved (including address)
	Doctor/HCP: Street: City: State: Zip:
	Doctor/HCP: Street: City: State: Zip:
	Doctor/HCP: Street: City: State: Zip:
	Doctor/HCP: Street: City: State: Zip:
	Doctor/HCP: Street: City: State: Zip:
	Doctor/HCP: Street: City: State: Zip:

(g) Identify by name and address the doctor(s), nurse(s), hospital(s), or other healthcare provider(s) who flushed or otherwise maintained your Bard Implanted Port Catheter Product and provide the approximate date(s) for each:

Approximate Date(s)/Date Range(s)	Doctor or Healthcare Provider Involved (including address)
	Doctor/HCP: Street: City: State: Zip:
	Doctor/HCP: Street: City: State: Zip:
	Doctor/HCP: Street: City: State: Zip:
	Doctor/HCP: Street: City: State: Zip:
	Doctor/HCP: Street: City: State: Zip:

25. Are You making a claim for lost wages or lost earning capacity relating to injuries You allege to have been caused by the Bard Implanted Port Catheter Product?

Yes/No:_____

(a) If yes, state the annual gross income derived from Your employment for each year, beginning five (5) years prior to the implantation of the Bard Implanted Port Catheter Product until the present:

(b) If yes, for what period of time are You claiming lost wages?

(c) If You are claiming lost earning capacity, do You claim that You have a claim for future lost wages?

Yes/No:_____

If yes, for what period of time do You claim You have lost future wages?

26. Are You making a claim for out-of-pocket expenses? Yes/No:_____

If yes, please identify and itemize all out-of-pocket expenses You have incurred.

27. If anyone filed a loss of consortium claim in connection with Your lawsuit regarding the Bard Implanted Port Catheter Product, state the relationship of that person to You and state the specific nature of the Consortium Plaintiff's claim.

28. If anyone filed a loss of consortium claim in connection with Your lawsuit regarding the Bard Implanted Port Catheter Product, provide the Consortium Plaintiff(s) Social Security Number: _____

29. If anyone filed a loss of consortium claim in connection with Your lawsuit regarding the Bard Implanted Port Catheter Product, please indicate whether the Consortium Plaintiff alleges any of the damages set forth below:

Claims	Yes/No
Loss of services of spouse	
Impaired sexual relations	
Lost wages/lost earning capacity	
Lost out-of-pocket expenses	
Physical injuries	
Psychological injuries/emotional injuries	
Other	

30. Please list the name and address of any healthcare providers the Consortium Plaintiff has sought treatment from for any physical, emotional, or psychological injuries or symptoms alleged to be related to his/her claim.

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31. Have You or anyone acting on Your behalf had any communication, oral or written, with any of the Bard Defendants and/or their representatives regarding Your Bard Implantable Port Product?

Yes/No/Don't Know: _____

(a) If yes, set forth: (i) the date of any communication, (ii) the method of communication, (iii) the name of the person with whom You communicated, and (iv) the substance of the communications.

III. MEDICAL BACKGROUND

32. In chronological order, list any and all surgeries, procedures and/or hospitalizations You had in the ten (10) year period BEFORE implantation of the first Bard Implanted Port Catheter Product(s). Identify by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved with each surgery or procedure; and provide the approximate date(s) for each:

Approximate Date	Description of Surgery or Hospitalization	Doctor or Healthcare Provider Involved (including address)
		Doctor/HCP: Street: City: State: Zip:
		Doctor/HCP: Street: City: State: Zip:
		Doctor/HCP: Street: City: State: Zip:
		Doctor/HCP: Street: City: State: Zip:
		Doctor/HCP: Street: City: State: Zip:

33. In chronological order, list any and all surgeries, procedures and/or hospitalizations You had AFTER implantation of the Bard Implanted Port Catheter Product(s). Identify by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved with each surgery or procedure; and provide the approximate date(s) for each:

Approximate Date(s)	Description of Surgery or Hospitalization	Doctor or Healthcare Provider Involved (including address)
		Doctor/HCP: Street: City: State: Zip:
		Doctor/HCP: Street: City: State: Zip:
		Doctor/HCP: Street: City: State: Zip:
		Doctor/HCP: Street: City: State: Zip:
		Doctor/HCP: Street: City: State: Zip:
		Doctor/HCP: Street: City: State: Zip:

34. To the extent not already provided in the charts above, provide the name, address, and telephone number of every doctor, hospital or other health care provider from which You have received medical advice and/or treatment from ten (10) years before the date the Bard Implanted Port Catheter Product(s) was implanted to the present:

Name and Specialty	Address	Approximate Date/ Years of Visits
Name: Speciality:	Street: City: State: Zip:	
Name: Speciality:	Street: City: State: Zip:	
Name: Speciality:	Street: City: State: Zip:	
Name: Speciality:	Street: City: State: Zip:	
Name: Speciality:	Street: City: State: Zip:	
Name: Speciality:	Street: City: State: Zip:	
Name: Speciality:	Street: City: State: Zip:	

Name and Specialty	Address	Approximate Date/ Years of Visits
Name: Speciality:	Street: City: State: Zip:	
Name: Speciality:	Street: City: State: Zip:	
Name: Speciality:	Street: City: State: Zip:	
Name: Speciality:	Street: City: State: Zip:	
Name: Speciality:	Street: City: State: Zip:	
Name: Speciality:	Street: City: State: Zip:	
Name: Speciality:	Street: City: State: Zip:	

35. To the best of Your knowledge, have You ever been told by a doctor or another health care provider that You have suffered, may have suffered, or presently do suffer from any of the following:

Condition	Yes/No/Unsure	Describe (as applicable)
Anaphylaxis		
Blood Infection (Bacteremia or sepsis)		
Bone Infection (Osteomyelitis)		
Cancer (identify type)		
Cerebrovascular accident (Stroke)		
Chronic Kidney Disease		
Any disease you were born with (i.e., Hemophilia, Sickle Cell Disease, Cystic Fibrosis, etc.)		
Dehydration (Severe)		
Diabetes		
Gout		
Heavy Metal Exposure or poisoning		
Hepatitis A, B, or C		
Rhabdomyolysis		
Shock (hypotension)		

Condition	Yes/No/Unsure	Describe (as applicable)
Systemic Inflammatory Response Syndrome		
Any bacterial, viral, parasitic, or fungal infection (Streptococcus, A & B; Enterococcus E. Coli, adenovirus, mycobacterium, legionella, Epstein-Barr virus (EBV), Cytomegalovirus (CMV), Toxoplasmosis, Tuberculosis, HIV, Malaria, Mycobacterium, etc.)		
Liver disease (Cirrhosis), failure		
Metabolic disturbances		
Obesity		
Kawasaki Disease		
Protein Deficiency		
Prior Surgeries (Gastric Bypass, Spine surgery, etc.)		
Deep Vein Thrombosis		
Pulmonary Embolism		
Auto Immune Disorders (i.e., Lupus, HIV, Goodpasture Syndrome, Sarcoidosis, etc.)		
Varicose Veins		
Heart Procedures		
Cardiovascular disorders (i.e., atrial fibrillation, stenosis, vasculitis, Hypertension, Myocardial Infarction, Heart Attack)		

Condition	Yes/No/Unsure	Describe (as applicable)
Blood Disorders (i.e., Prothrombin mutation, Factor V Leiden, Anti-thrombin Deficiency)		
Anticoagulation Medication (Coumadin, Warfarin, Eliquis (Apixaban))		
Ulcerative Colitis/Inflammatory Bowel Disease (IBD), Crohn's disease		
Lung Disease/disorders		
Prior treatment with radiation		

* * * * * * * * * *

THE FOLLOWING QUESTIONS ARE CONFIDENTIAL AND SUBJECT TO THE PROTECTIVE ORDER APPLICABLE TO THIS CASE.

(A) Have You been diagnosed with and/or treated for any drug, alcohol, chemical and/or other addiction or dependency during the five (5) years prior to the implant of your (first) Bard Implanted Port Catheter Product through the present?

Yes/No: _____

If yes:

Type	Time period of dependency	Type of treatment received	Name of treatment provider	Current status

(B) Have You experienced, been diagnosed with or received psychiatric or psychological treatment of any type, including therapy, for any mental health conditions including depression, anxiety, or other emotional or psychiatric disorders during the five (5) years prior to the implant of your (first) Bard Implanted Port Catheter Product?

Yes/No:_____

If yes, specify condition, date of onset, medication/treatment, treating physician and current status of condition:

Condition	Date of onset	Medication/treatment	Treating physician	Current status of condition

36. Do You now or have You ever smoked tobacco products? Yes/ No: _____

If yes:

How long have/did You smoke?_____

37. Other than the implantation of the Bard Implanted Port Catheter Product(s) device that is the subject of Your lawsuit, were you implanted with any other Implanted Port Catheter Product at any time? Yes/ No: _____

If yes, please provide the following information relating to each Port Catheter Product implanted:

(a) Date of implant: _____

Lot number: _____

Product Code: _____

Model name: _____

(b) Name and address of the healthcare provider who implanted this other device or product?

_____

(c) At what hospital or facility was this device or product implanted in You?

_____

(d) Why was this device implanted in You?

_____

(e) How long did you have this device implanted in You?

_____

(f) Did You experience any complication as a result of the implantation of this device?

Yes/No: _____

If Yes:

(i) Describe the complication You experienced.

_____

(g) Identify by name and address the doctor(s), nurse(s), hospital(s), or other healthcare provider(s) who accessed Your Other Implanted Port Catheter Product(s) and provide the approximate date(s) for each such occurrence:

Approximate Date(s)/Date Range(s)	Doctor other Healthcare Provider (including address)
	Name: Street: City: State: Zip:
	Name: Street: City: State: Zip:
	Name: Street: City: State: Zip:
	Name: Street: City: State: Zip:

Approximate Date(s)/Date Range(s)	Doctor, Nurse, Hospital, or other Healthcare Provider (including address)
	Name: Street: City: State: Zip:
	Name: Street: City: State: Zip:
	Name: Street: City: State: Zip:
	Name: Street: City: State: Zip:
	Name: Street: City: State: Zip:
	Name: Street: City: State: Zip:

(h) Identify by name and address the doctor(s), nurse(s), hospital(s), or other healthcare provider(s) who flushed or otherwise maintained Your Other Implanted Port Catheter Product(s) and provide the approximate date(s) for each:

Approximate Date(s)/Date Range(s)	Doctor or Healthcare Provider Involved (including address)
	Name: Street: City: State: Zip:
	Name: Street: City: State: Zip:
	Name: Street: City: State: Zip:
	Name: Street: City: State: Zip:
	Name: Street: City: State: Zip:

(i) Was this device or product removed?

Yes/No: _____

If Yes:

(ii) When was it removed?

_____

(iii) Why was it removed?

_____

(iv) By whom and at what hospital or facility was it removed?

_____

(i) Are You currently implanted with an implantable port catheter device or some other venous access device?

Yes/No:_____

If Yes:

(i) What is the name of the device, when was it implanted, what is the name of the institution where it was implanted, and why was it implanted?

_____

38. List each prescription medication You have taken for more than three (3) months at a time during the timeframe beginning five (5) years prior to implantation of the Bard Implanted Port Catheter Product(s) and continuing to the present, giving the name and address of the pharmacy where You received/filled the medication, the reason You took the medication, and the approximate dates of use.

Medication and Dosage	Prescribing Physician	Pharmacy Name and Address	Reason for Taking Medication	Approximate Date(s) of Use
		Name: Street: City: State: Zip:		
		Name: Street: City: State: Zip:		
		Name: Street: City: State: Zip:		
		Name: Street: City: State: Zip:		
		Name: Street: City: State: Zip:		
		Name: Street: City: State: Zip:		

Medication and Dosage	Prescribing Physician	Pharmacy Name and Address	Reason for Taking Medication	Approximate Date(s) of Use
		Name: Street: City: State: Zip:		
		Name: Street: City: State: Zip:		
		Name: Street: City: State: Zip:		
		Name: Street: City: State: Zip:		
		Name: Street: City: State: Zip:		
		Name: Street: City: State: Zip:		

IV. INSURANCE INFORMATION

39. Provide the following information for any past or present medical insurance coverage from the timeframe beginning five (5) years prior to implantation of the Bard Implanted Port Catheter Product(s) and continuing to the present:

Insurance Company Name and Address	Policy Number	Name of Policy Holder/Insured (if different than Yourself)	Approximate Dates of Coverage
Name: Street: City: State: Zip:			
Name: Street: City: State: Zip:			
Name: Street: City: State: Zip:			
Name: Street: City: State: Zip:			
Name: Street: City: State: Zip:			
Name: Street: City: State: Zip:			

Insurance Company Name and Address	Policy Number	Name of Policy Holder/Insured (if different than Yourself)	Approximate Dates of Coverage
Name: Street: City: State: Zip:			
Name: Street: City: State: Zip:			

40. To the best of your knowledge, have You ever been approved to receive or are you currently receiving Medicare/Medicaid benefits due to age, disability, condition, or any other reason or basis?

Yes/No:_____

If yes, please specify the date on which You first became eligible: _____

[Please note: if you are not currently a Medicare-eligible beneficiary, but become eligible for Medicare during the pendency of this lawsuit, you must supplement your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C. 1395y(b)(8), also known as Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 and 42 U.S.C. 1395y(b)(2) also known as the Medicare Secondary Payer Act.]

V. PRIOR CLAIM INFORMATION

41. Have You filed a lawsuit or made a claim in the last ten (10) years, other than in the present suit relating to any bodily injury?

Yes/No:_____

If yes, for each, please specify the following:

Court in which the lawsuit/claim was filed or initiated	Case/Claim Number	Nature of Claim/Injury:

42. Have You ever applied for Workers' Compensation (WC), Social Security disability (SSI or SSD) benefits, or other State or Federal disability benefits?

Yes/No: _____

If yes, please specify the following:

Date (or year) of application	Type of benefits sought	Agency/Insurer from which You sought the benefits	Nature of the claimed injury/ disability	Whether the claim was accepted or denied

Date (or year) of application	Type of benefits sought	Agency/Insurer from which You sought the benefits	Nature of the claimed injury/ disability	Whether the claim was accepted or denied

43. Have You ever filed bankruptcy?

Yes/No: _____

If yes, please specify the following:

Date (or year) of filing	Venue where filed	Docket Number	Disposition	Date of disposition

VI. FACT WITNESSES

44. Identify by name, address, and relationship to You, all persons (other than Your healthcare providers) who possess information concerning Your injuries and/or current medical condition:

Name	Address	Relationship to You	Information You Believe Person Possess
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		

VII. IDENTIFICATION OF DOCUMENTS AND OTHER ELECTRONICALLY STORED INFORMATION

For the period beginning three (3) years prior to the implantation of the Bard Implanted Port Catheter Product(s) until the present, please identify all research, including on-line research, that You conducted regarding the medical complaints or condition for which You received the Bard Implanted Port Catheter Product(s). Identify the date, time, and source, including any websites visited. (Research conducted subsequent to and for the purpose of understanding the legal and strategic advice of Your counsel is not considered responsive to this request.)

VIII. DOCUMENT REQUESTS

Plaintiff(s)'s document collections and productions shall comply with Case Management Order No. 12, including collection of electronically stored information in a manner that preserves the underlying data and reasonable available metadata, as well as the search methodologies that Plaintiff(s) will employ or have employed to identify responsive information. See Section III.B. and Section IV.D.2. of Case Management Order No. 12.

1. Upload to MDL Centrality all of Your medical records relating to Your Bard Implanted Port Product(s) and the injuries You claim in this lawsuit in Your possession or the possession of Your attorney(s).

   ☐ The documents are uploaded.

   ☐ I have no records.

2. Upload to MDL Centrality each and every medical record in your possession or in the possession of your attorney(s) from each and every medical facility, pharmacy, and practitioner of the healing arts identified by You in Sections II and III above regarding Your medical care and history for the time period beginning ten (10) years prior to the implantation of the Bard Implanted Port Catheter Product(s) and continuing to the present.

☐ The documents are uploaded.

☐ I have no records.

3. RELEASES.

NOTE: Please sign and produce/upload in MDL Centrality the requisite authorizations for the release of records, which are appended hereto. Releases cannot be signed electronically.

☐ The executed releases are uploaded.

4. DOCUMENTS.

State whether You have any of the following documents in Your possession, custody, and/or control. If You do, please produce/upload the documents in MDL Centrality.

(a) If You were appointed by a Court to represent the plaintiff in this lawsuit, produce any documents demonstrating such appointment.

(i) ☐ Not applicable

(ii) ☐ The documents are uploaded.

☐ I have no records.

(b) If You represent the Estate of a deceased person in this lawsuit, produce a copy of the decedent's death certificate and autopsy report (if applicable).

(i) ☐ Not applicable

(ii) ☐ The documents are uploaded.

☐ I have no records.

(c) Upload to MDL Centrality any communication (sent or received) in Your possession, which shall include materials accessible to You from any computer on which You have sent or received such communications, concerning the Bard Implanted Port Catheter Product(s) or subject of this litigation, including, but not limited to all letters, emails, blogs, Facebook posts, Tweets, newsletters, Instagram or other social media posts, Slack messages, Snapchat messages, etc. sent or received by You. (Research conducted subsequent to retention of an attorney is not considered responsive to this request if it was conducted to understand the legal and strategic advice of Your counsel.)

(i) ☐ Not applicable

(ii) ☐ The documents are uploaded.

☐ I have no records.

(d) Produce all documents, including journal entries, calendar entries, lists, memoranda, notes, diaries, photographs, video, DVDs or other media, discussing or referencing the Bard Implanted Port Catheter Product(s), the injuries and/or damages You claim resulted from the Bard Implanted Port Catheter Product(s), and/or evidencing Your physical condition from three (3) years prior to the implantation of the Bard Implanted Port Catheter Product(s) to present. (Research conducted subsequent to retention of Your attorney and to understand the legal and strategic advice of Your counsel is not considered responsive to this request.)

(i) ☐ The documents are uploaded.

☐ I have no records.

(e) Produce any Bard Implanted Port Catheter Product(s) packaging, labeling, advertising, or any other product-related items in Your possession, custody or control. This request includes but is not limited to any materials related to Bard Implanted Port Catheter Product(s) that You may have received from any healthcare provider.

(i) ☐ The documents are uploaded.

☐ I have no records.

(f) Produce all documents concerning any communication between You, Your attorney(s), Your agent(s), Your expert(s), or Your representative(s) and the Food and Drug Administration (FDA), or between You and any employee or agent of the Bard Defendants, regarding Bard Implanted Port Catheter Product(s).

(i) ☐ The documents are uploaded.

☐ I have no records.

(g) Produce all documents that You, Your attorney(s), Your agent(s), Your expert(s), or Your representative(s) provided to the Food and Drug Administration (FDA) and/or the Department of Health and Human Services regarding Bard Implanted Port Catheter Product(s).

(i) ☐ The documents are uploaded.

☐ I have no records.

(h) Produce all documents concerning any communication between You, Your attorney(s), Your agent(s), Your expert(s), or Your representative(s) with anyone at any television station, radio station, newspaper, periodical, magazine, weblog, internet website, or any other media outlet regarding Bard Implanted Port Catheter Product(s).

(i) ☐ The documents are uploaded.

☐ I have no records.

(i) Produce all documents that You, Your attorney(s), Your agent(s), Your expert(s), or Your representative(s) provided to anyone at any television station, radio station, newspaper, periodical, magazine, weblog, internet website, or any other media outlet regarding Bard Implanted Port Catheter Product(s).

(i) ☐ The documents are uploaded.

☐ I have no records.

(j) Produce all documents in Your possession, custody, or control evidencing or relating to any correspondence or communication between Bard Access Systems; C. R. Bard, Inc.; Bard Peripheral Vascular, Inc.; or Becton, Dickinson and Company (or any related companies or divisions) and any of Your doctors, healthcare providers, and/or You relating to Bard Implanted Port Catheter Product(s), except as to those communications which are protected by the attorney-client privilege or attorney work product doctrine.

(i) ☐ The documents are uploaded.

☐ I have no records.

(k) Produce all documents in Your possession, custody, or control reflecting, describing, or in any way relating to any instructions or warnings You received prior to implantation of any Implanted Port Catheter Product(s) concerning the risks and/or benefits associated with Implanted Port Catheter Product(s), including but not limited to the Bard Implanted Port Catheter Product(s) implanted in You.

(i) ☐ The documents are uploaded.

☐ I have no records.

(l) If You underwent surgery or any other procedure to remove, in whole or in part, the Bard Implanted Port Catheter Product(s), produce any and all documents, other than documents that may have been generated by expert witnesses retained by Your counsel for litigation purposes, that relate to any evaluation of the Bard Implanted Port Catheter Product(s) removed from You.

(i) ☐ The documents are uploaded.

☐ I have no records.

(m) Produce all documents in Your possession, custody, or control concerning payment by Medicare on behalf of the injured party and relating to the injuries claimed in this lawsuit. This includes but is not limited to Interim Conditional Payment summaries and/or estimates prepared by Medicare or its representatives regarding payments made on Your behalf for medical expenses relating to the subject of this litigation.

(i) ☐ The documents are uploaded.

☐ I have no records.

[Please note: if You are not currently a Medicare-eligible beneficiary but become eligible for Medicare during the pendency of this lawsuit, You must supplement Your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C. 1395y(b)(8), also known as Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 and 42 U.S.C. 1395y(b)(2) also known as the Medicare Secondary Payer Act.]

(n) Produce all screenshots of all webpages of each type of social media used by You (including, but not limited to, Facebook, Twitter, Instagram, Vine, Snapchat, YouTube, LinkedIn, TikTok, Slack, or any other social media) showing any and all "posts" and/or "messages" from the date of implantation to the present.

(i) ☐ The documents are uploaded.

☐ I have no records.