NIGH GOLDENBERG RASO & VAUGHN

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

IN RE: EXACTECH POLYETHYLENE ORTHOPEDIC PRODUCTS LIABILITY LITIGATION	**MDL No. 3044** **Case No. 1:22-md-3044 (NGG) (MMH)**
This Document Applies to All Cases	**SECOND AMENDED FACT SHEET IMPLEMENTATION ORDER**

It is hereby ORDERED that the Amended Fact Sheet Implementation Order dated March 23, 2023 (Dkt. # 166) is amended to provide that the Plaintiff Fact Sheet, attached as **Exhibit A**, shall be completed by all Plaintiffs (1) within seventy-five days of the direct filing of a case in the MDL or the transfer of a complaint to the MDL, or (2) by June 6, 2023, whichever is later. All other aspects of the Amended Fact Sheet Implementation Order dated March 23, 2023 (Dkt. # 166) are unchanged by this Order and remain binding on the Parties.

DATED: April 14, 2023

Marcia M. Henry
The Honorable Marcia M. Henry
United States Magistrate Judge

EXHIBIT A

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK

IN RE: EXACTECH POLYETHYLENE ORTHOPEDIC PRODUCTS LIABILITY LITIGATION	)))))))	MDL Docket No. 3044 THE HON. NICHOLAS G. GARAUFIS & THE HON. MARCIA M. HENRY

PLAINTIFF'S FACT SHEET

This Plaintiff's Fact Sheet ("PFS") must be completed by the plaintiff or the representative of plaintiff's decedent within 75 days of the filing of the Complaint or 75 days from the date of the implementation order, whichever is later. No objections may be made to the questions. Answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, provide as much information as you can. You must supplement your responses if you learn that they change or are incomplete or incorrect in any material respect. For each question, where the space provided does not allow for a complete answer, attach additional sheets so that all answers are complete. When attaching additional sheets, clearly label what question your answer pertains to.

In filling out this form, use the following definitions: (1) "**health care provider**" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care, and if claims are made for psychological, cognitive, and/or mental health problems other than "garden variety" emotional distress, psychiatric, or psychological care or advice, and any pharmacy, dietary, nutrition or weight loss, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, osteopath, homeopath, chiropractor, or other persons or entities involved in the evaluation, diagnosis, care, and/or treatment of the plaintiff or plaintiff's decedent; (2) "**document**" means any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, e-mail communications; text messages; social network or Internet postings, social network other app-based messages; iMessages, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone records, non-identical copies, and other data compilations from which information can be obtained and translated, if necessary, by the defendants through electronic devices into reasonably usable form.

Information provided in this PFS will only be used for purposes related to this litigation and medical records will be destroyed upon the completion of the litigation provided that this individual case is dismissed with prejudice. This Fact Sheet is completed pursuant to the Federal Rules of Civil Procedure governing discovery (or, for state court case, the governing rules of the state in which the case is pending).

1. CASE INFORMATION

Name of Person Completing Form:	
If you are completing this PFS in a representative capacity (e.g., on behalf of the estate of a deceased person), please complete the following:	
Your Name:	
Other Names and the Dates You Used Those Names:	
Your Address:	
Individual You Represent, and Your Capacity as Representative:	
Your Relationship to Individual You Represent:	
Court Who Appointed You as Representative (if any):	
Date You Were Appointed: [Calendar Drop Down]	
Individual Case Number:	

THE REST OF THIS PLAINTIFF'S FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO WAS IMPLANTED WITH AN EXACTECH PRODUCT.

2. PERSONAL INFORMATION

Name:	
Maiden/Other Names Used:	
Current or Last Known Address:	
Year You Began Living at This Address: [Calendar Drop Down]	
All Persons Who Have Lived with You from the Date You Were	

First Implanted to the Present:		
Date of Birth: [Calendar Drop Down]		Sex: M/F [Drop Down]
Place of Birth:		Driver's License Number and Issuing State (for all driver's licenses you have):
Date of Death (if applicable): [Calendar Drop Down]		Social Security Number:
Marital Status:	[DROP DOWN] Single Married Widowed Divorced Separated	Name of Spouse, if Married at time of filing Complaint:

a. Identify each address at which you have resided at the time of your implant surgery with an Exactech device and also for the last five (5) years, and list the approximate years when you started and stopped living at each address:

Address	**Dates of Residence (drop down – year started and year ended)**

b. Are you currently, or have you ever been, married or in a domestic partnership/civil union? Yes/No [DROP DOWN]

If Yes, for each spouse/partner, please state the following:

Name & Address of Spouse/Partner	Spouse/Partner's Date of Birth [Calendar Drop Down]	Date Marriage/Domestic Partnership Began and Ended [Calendar Drop Down]	How Marriage/Domestic Partnership Ended

c. For each of your living children, if any, list the following:

Child's Name	Date of Birth

d. Within the last ten (10) years, have you been convicted of, or plead guilty to, a felony of fraud or dishonesty and/or a crime of fraud or dishonesty? Yes/No [DROP DOWN]

If Yes, state the following:

Nature of Crime	Date of Crime [Calendar Drop Down - year]	Location of Crime

3. MEDICAL BACKGROUND

Current height:	
Please state your weight at the following times:	Current:
	Time of each implant at issue:
	Time of each revision surgery (if any):

a. Have you ever had an allergic reaction? Yes/No [DROP DOWN]

If Yes, please state the following:

Type of Allergy (e.g., food, drug, cosmetic)	**When Allergy Was Diagnosed (drop down – year)**	**Symptoms of Allergy**	**Name & Address of Health Care Provider Who Diagnosed Allergy**	**Treatment Received, If Any**

b. Have you ever been diagnosed with any of the following?

Condition	**Yes/No/Unknown [DROP DOWN]**	**Name and Address of Diagnosing Provider**	**Approximate Date of Diagnosis (if applicable)**
Acetabular perforation			
Adverse local tissue reaction (ALTR)			
Alcohol Addiction			
Aseptic Lymphocyte-Dominated Vasculitis-Associated Lesion (ALVAL)			
Asthma			
Avascular necrosis			
Neck or spinal injury or condition			
Blood clots			
Bone fracture			
Cancer (including blood cancers)			
Charcot's disease			
Chronic Fatigue Syndrome			
Colitis or Ulcerative Colitis			
Congenital dysplasia of the hip			

Crohn's Disease treated with medication			
Deep Vein Thrombosis (DVT)			
Degenerative joint or disc disease			
Diabetes			
Drug addiction			
Eczema			
Femoral shaft perforation, fissure, or fracture			
Fibromyalgia			
Heart attack/Myocardial infarction (MI)			
Hay fever			
Immunodeficiency disorders			
Infections lasting longer than a week or occurring more frequently than monthly			
Inflammatory bowel disease			
Liver disease			
Lupus			
Lyme Disease			
Neuromuscular compromise or vascular deficiency			
Osteolysis			
Paget's Disease			
Periarticular calcification or ossification			
Peripheral neuropathies or nerve damage			
Poor bone quality (e.g., osteoporosis)			
Reflex Sympathetic Dystrophy Syndrome (RSDS) or Complex Regional Pain Syndrome (CRPS)			
Rheumatoid Arthritis			
Rheumatic Disorders or Diseases other than Rheumatoid Arthritis			
Renal insufficiency			
Skeletal hyperostosis			
Slipped Capital Femoral Epiphysis			
Subluxation or dislocation of the hip joint			
Treatment with non-topical steroids for two consecutive months			
Trochanteric fracture			
Pseudotumor			

c. Identify each hospital, clinic, surgery center, or healthcare facility where you have undergone a surgical procedure (whether in-patient or out-patient) from five (5) years before your first implant surgery to the present:

Name of Facility	Treating Physician and Address	Approximate Dates of Surgery or Procedure	Surgery or Procedure Performed

d. Other than the implantation of the Exactech product(s) at issue, have you had implanted in your body any other medical product of any kind (including joint-related and not joint-related implants, but excluding dental filings, crowns, and bridges)? Yes/No [DROP DOWN]

If Yes, please state the following:

Product Name	Date of Implantation Drop down month and year	Name & Address of Implanting Surgeon	Condition Sought to be Treated	Complications with Device or Procedure	Still Implanted in Your Body Today

e. Have you ever participated in any clinical trial or studies relating to any medical devices, drugs, or treatments for any joint-related medical condition(s)? Yes/No/Do not know [DROP DOWN]

If Yes, please identify:

Name of Trial/Study	Sponsor of Trial/Study	Drug, Device, or Treatment Studied	Purpose of Drug, Device, or Treatment Studied	Dates You Participated in Trial/Study (drop down year)

f. To the best of your recollection, list each prescription or over the counter medication, you have regularly taken (i.e., daily over the course of three months or more) in the five (5) years prior to your first implant surgery with an Exactech product to the present,

Medication	Start & End Dates of Use	Dose & Frequency	Prescribing Physician (if any)	Dispensing Pharmacy (if any)	Purpose

4. IMPLANT/EXPLANT INFORMATION

a. Please provide the following information regarding your implantation surgery(ies).

Name(s) and Address(es) of Implanting Surgeon(s):	
Name(s) and Address(es) of Hospital(s) or Clinic(s) where surgery performed:	

b. With what type of prosthesis were you implanted? For each prosthesis, indicate on which side of your body it was implanted and the date(s) of implantation.

Type of Prosthesis	Date of Implantation	Right	Left
Optetrak Classic			
Optetrak Logic			
Truliant			
Vantage			
Connexion GXL			
Conventional UHMWPE Hip Liner			

c. List the item number(s) and serial number(s) that corresponds to your prostheses. Provide all codes, including those relating to the polyethylene component.

[OPEN FIELD]

d. Describe the condition for which the Exactech product(s) at issue was/were implanted:

[OPEN FIELD]

e. Identify the healthcare provider who diagnosed you with the above condition(s) by name and address:

[OPEN FIELD]

f. Provide the following information regarding your revision surgery(ies), if any.

Date(s) of Revision Surgery:	
Name(s) and Address(es) of Revision Surgeon(s):	
Name(s) and Address(es) of Revision Surgery Hospital(s):	
Manufacturer(s) and Name/Model of Replacement Device(s):	

g. Identify who is currently in possession of your explanted components unless the Exactech product(s) at issue is/are in the possession of a consulting or testifying expert, in which case answer "in possession of expert" but do not reveal the identity of the expert:

[OPEN FIELD]

h. If none of your Exactech product(s) has/have been explanted, has any doctor advised you that you will need to have your Exactech product(s) explanted at some time in the near future? Yes/No [DROP DOWN]

If Yes, state the following:

Name of Doctor:	
Address of Doctor:	
Reason for Recommending That Exactech Product(s) Be Explanted:	
Exactech Product(s) Recommended for Removal:	
Date You Were So Advised: [Calendar Drop Down]	
Do You Intend to Have Your Device Explanted? Y/N [Drop Down]	
If Yes, When?	
If No, Why Not?	

i. Was/were any imaging study(ies) (e.g., MRI/CT/Ultrasound) conducted in connection with your implant or revision surgery(ies)? Yes/No [DROP DOWN]

If Yes, list which reports are available and identify if known, from which facilities.

[OPEN FIELD]

j. Was/were any pathology study(ies) conducted in connection with your implant or revision surgery(ies)? Yes/No [DROP DOWN]

If Yes, list which reports and/or specimens are available:

[OPEN FIELD]

5. CURRENT CLAIM INFORMATION

a. Do you allege that you experienced, or are currently experiencing, a physical and/or bodily condition or illness as a result of the Exactech product(s) at issue? Yes/No [DROP DOWN]

If Yes, please describe your physical and/or bodily conditions or illnesses and state whether you are currently experiencing the physical and/or bodily conditions or illnesses:

[OPEN FIELD]

b. Do you claim that you have any of the below conditions as a result of your Exactech implant? If so mark "X" for all conditions that apply:

Condition	**Left Side**	**Right Side**
Bone loss requiring grafting		
Constrained liner placement surgery		
Damage to abductor muscle requiring surgical repair		
Debridement of necrotic tissue		
Disassociation of femoral head		
DVT, Pulmonary Embolism, or Myocardial Infarction During Hospitalization for Revision Surgery or within 8 weeks after discharge _____ Effusion (excess fluid causing swollen knee)		
Elevated Metal Ion Levels		
Extended Trochanteric Osteotomy (for Femoral Stem Removal)		
Femoral Stem Loosening		
Foot Drop		
Fracture (bone)		
Fracture (femoral stem or femoral neck)		
Girdlestone --- Need for Hinge Knee Replacement		
Hip Dislocation		
Hip Dislocation-related Treatment: Closed Reduction *[Identify Number of Closed Reductions:]*		
Hip Dislocation-related Treatment: Open Reduction *[Identify Number of Open Reductions:]*		
Infection (in the hip, knee or ankle)		
Infection (in the hip, knee or ankle) related Treatment: IV antibiotics		
Infection (in the hip, knee or ankle) related Treatment: Surgery to Implant Antibiotic Spacer		
Infection (in the hip, knee or ankle) related Treatment: Surgery to Place Wound Vacuum		

Infection (in the hip, knee or ankle) related Treatment: Irrigation and Debridement (I&D) Surgery		
Loosening of acetabular cup or polyethylene liner		
Metallosis/Metal Wear/Corrosion _____ Nonnunion fracture		
Osteolysis _____ Pseudotumor		
Placement of Cabling or Hardware for Femur Fracture		
Re-Revision Surgery(ies)		
Tibial Tray Loosening		
Femur Fracture		
Amputation		
Death		
Other (please describe): [OPEN FIELD]		

c. For each condition or illness identified above, please state the following:

Condition	**Approx. Date of Treatment**	**Name & Address of Treating Healthcare Provider**

d. Describe any activities (i.e., of daily living, vocation, or recreation) that you can no longer perform or participate in, or cannot perform or participate in as well or actively in the past, since the time you experienced the physical and/or bodily condition(s) or illness(es):

[OPEN FIELD]

e. Do you allege that the Exactech product(s) at issue worsened a previously existing condition? Yes/No [DROP DOWN]

If Yes, describe the previously existing condition, the approximate date of onset of the previously existing condition, and any treatment for and resolution of the previously existing condition:

[OPEN FIELD]

f. Have you or anyone acting on your behalf, other than your attorney, ever communicated directly with, or received communications directly from Broadspire? DROP DOWN yes/ no. If YES, state the approximate date of the first communication.

g. Have you or anyone acting on your behalf, other than your attorney, ever communicated directly with or received communications directly from any Exactech representative or lawyer, whether face-to-face, by telephone, or written communication? es/No [DROP DOWN]

If Yes, please state the following

Date of Communication	**Name of Person with Whom You Communicated**	**Mode of Communication**	**Describe Substance of Communication**

h. Did you read or rely upon any documents or other information from Exactech prior to the date of your Exactech product implantation surgery es/No [DROP DOWN]

If Yes, for each, please state the following:

Document/Source of Information	**Date You Read Document/Received Information**	**How You Obtained Document/Information**

If you have a copy of any of the documents that you listed, please produce a copy of it together with your answers to the Plaintiff's Fact Sheet.

If you no longer have the document or written information, please describe the information that you received to the best of your recollection:

[OPEN FIELD]

i. Did you read or rely upon any documents or other information specifically relating to the Exactech product(s) implanted prior to your surgery? Yes/No [DROP DOWN]

If Yes, please state the following:

Document/Source of Information	Date You Read Document/Received Information	How You Obtained Document/Information

If you have a copy of any of the documents that you listed, please produce a copy of it together with your answers to the Plaintiff's Fact Sheet.

If you no longer have the document or written information, please describe the information that you received to the best of your recollection:

[OPEN FIELD]

j. Were you given any oral or written instructions, warnings, or other information on the Exactech product(s) and/or the implantation of the Exactech product(s)? Yes/No/Do not recall [DROP DOWN]

If Yes, please state the following:

When Did You Receive the Information?	Who Gave You the Information?	Oral or Written	Do You Have a Copy of This Document?

If you have a copy of any of the information that you listed, please produce a copy of it together with your answers to the Plaintiff's Fact Sheet.

If you no longer have the document or written information, please describe the information that you received to the best of your recollection:

[OPEN FIELD]

6. HEALTHCARE PROVIDERS

a. Identify each of the below whom you have seen for medical care and treatment for the period five (5 years) before your first implant surgery to the present, but for any medical care and treatment for any of your bones or joints, please answer the question for ten (10) years before your first implant surgery to the present

1) Doctor or healthcare provider (including but not limited to family/primary care physicians, physical therapists, and/or chiropractors);

2) Any hospital, clinic, surgery center, healthcare facility, physical therapy or rehabilitation facility; and

3) Any facility at which you have had radiographs of the joint(s), i.e., hip, knee, or ankle at issue (x-rays, ultrasounds, MRIs, CT scans, bone scans).

Healthcare Provider	Address	Dates/Years of Visits drop down years	Reason for Visit

7. PSYCHOLOGICAL, COGNITIVE, MENTAL, AND/OR EMOTIONAL DISTRESS CLAIMS

[NOTE: All plaintiffs must answer Question (a) below. If the answer to Question (a) is "No", please skip to Section 8 – Economic Damages. If the answer to Question (a) is "Yes", please answer Questions (b)–(d) below.]

a. Do you claim emotional distress damages in this lawsuit? Yes/No [DROP DOWN]

b. Do you claim damages in this lawsuit for psychological, cognitive, and/or mental health problems, (including depression) or aggravation or exacerbation of a pre-existing mental health condition? Yes/No [DROP DOWN]

c.If you answered "yes" question b above, have you been treated for any psychological, cognitive, and/or mental health problems including depression, (but excluding *emotional distress*) conditions or illnesses prior to developing the condition(s) alleged in this lawsuit? Yes/No [DROP DOWN]

If you answered "yes" to both questions b and c above, please state the following:

Name & Address of Each Healthcare Provider Who Treated You	**Conditions for Which You Were Treated**	**Dates (month & year) Treated:**

8. EDUCATIONAL BACKGROUND

a. Identify the following information for each school or other educational institution you have attended, starting with high school:

Name of School/Educational Institution	**City and State**	**Dates of Attendance [Calendar DROP DOWN]**	**Highest Level of Education Completed [DROP DOWN]**		

9. ECONOMIC LOSS CLAIMS

a. Current employment:

Are you currently employed?	[DROP DOWN] Yes____ No____
If yes, identify your current employer and position:	

b. Prior employment:

For the period of time from five (5) years before your first revision surgery until the present, please identify the following information for your employers. If you have not been revised, please identify the information for the past five (5) years from today.

Name of Employer	City and State	Approximate Dates of Employment	Occupation or Job Title	Reason for Leaving [DROP DOWN] Resigned, Disabled, Laid Off, Terminated for Cause, Seasonal Position

c. Are you making a claim for past or future lost wages and/or loss of earning capacity? Yes/No [DROP DOWN]

If Yes, describe your claim(s). Your description should include the total amount of time (and amount of income) you have lost or will lose from work as a result of any condition that you claim or believe was caused by the Exactech product(s) at issue, and an explanation of how those amounts were calculated:

If you claim a loss of earnings, state your earned income from five (5) years prior to your If

[OPEN FIELD]

first revision surgery through the present. If you have not been revised, provide the information for the past five (5) years from the present.

Year	Annual Gross Income

d. Provide the following information for any other economic damages you are claiming:

Nature of Other Economic Damage	Approx. Dollar Amount

10. MILITARY BACKGROUND

Have you ever served in any branch of the U.S. Military?	[DROP DOWN] Yes____ No____
If yes, identify branch, rank, and dates of service:	
If yes, select discharge status:	[DROP DOWN] Honorable Other Than Honorable Bad Conduct Dishonorable Officer Discharge Entry-Level Separation Medical Discharge
Were you ever denied entry into the military for any reason relating to your medical or physical condition??	[DROP DOWN] Yes____ No____
Were you ever discharged from the military for any reason relating to your medical or physical condition??	[DROP DOWN] Yes____ No____
If you answered "yes" to either of the previous two questions, state the condition(s) and reasons for which you were denied entry or discharged:	

11. SOCIAL HISTORY

a. Do you currently use, or have you used, tobacco, including cigarettes, cigars, pipes, chewing tobacco/snuff, and/or electronic cigarettes? Yes/No [DROP DOWN]

If Yes, identify the following information:

Type of Tobacco	Date Tobacco Use Started	Amount Used on Average Per Day	Duration of Use

b. In the five years before your revision surgery, have you regularly consumed alcohol more than twice a week? Yes/No [DROP DOWN]

If Yes, identify the following information:

		Average Amount Consumed Per Week	Approx dates of use (DROP DOWN)

c. Have you ever had a personal website, blog, Facebook account, Instagram account, Snapchat account, LinkedIn account, or any other social media? Yes/No [DROP DOWN]. If you answered Yes, please supply for the period of five (5) years before your first revision surgery to the present. If you haven't revised, please supply the information for the past five (5) years to the present.

Web Address/Account Name	Type of Social Media

d. For the period from five (5) years before your first implant surgery to the present, please list any sport or exercise activities in which you have regularly participated in:

Type of Sport/Exercise	Dates/Years Played or Exercised	Approx. Number of Hours Played or Exercised Per Week

e. Please list any activities identified in the previous question that you can no longer perform, or cannot perform as well, which you allege is due to your implants which are the subject of this lawsuit.

[OPEN FIELD]

12. INSURANCE INFORMATION

a. Are you currently or have you ever been enrolled in Medicare or Medicaid? Yes/No [DROP DOWN]

[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.]

If Yes, please state the following:

Health Insurance Claim Number (HICN):	
Date (month/year) You Began Receiving Benefits:	

b. Identify any insurance company or other entity that provided medical coverage to you (either directly or through a group, including any employer) or paid medical bills on your behalf at any time, for the injuries you allege are related to your implant:

Name of Entity	Identification and/or Policy Number	Name of Policy Holder/Insured (if different than you)	Approx. Dates of Coverage

c. Have you ever received or applied for workers' compensation or social security, and/or state or federal disability benefits? Yes/No [DROP DOWN]

If Yes, as to each application separately, state the following:

Date/Year of Application:	
Place of Employment (name/address):	
Job Description at Time of Application:	
Type of Benefits:	
Nature of Claimed Injury/Disability:	
Period of Disability:	
Amount Awarded (if any):	
Basis of Your Claim:	
Claim Denied?	Y/N [DROP DOWN]
Agency/Company Application Was Submitted To:	
Claim/Docket Number, if Known:	

13. OTHER CLAIM INFORMATION

a. Have you ever been involved in an accident or other event as a result of which you sustained any physical injuries to your legs, hips, spine, back, knees, or pelvic area? Yes/No [DROP DOWN]

If Yes, please provide the following information and attach copies of any accident reports in your possession:

Date of Accident	**Location & Type of Accident**	**Type & Location of Injury**	**Activity at Time of Injury**	**Names & Address of Treating Physician**

b. Have you ever filed a lawsuit or made a claim against anyone related to any bodily injuries, including but not limited to a medical malpractice lawsuit or a lawsuit against a pharmaceutical and/or medical device company? Yes/No [DROP DOWN]

If Yes, please provide the following:

Parties You Sued/Made Claim Against	Court in Which Suit Filed/Made Claim	Case/Claim Number	Attorney Who Represented You	Nature of Claim and Injury

c. Have you or your spouse/partner (if the spouse/partner is a plaintiff) ever declared personal bankruptcy since the date of your first implant surgery to the present? Yes/No [DROP DOWN]

If Yes, please state the following:

Date Filed:	
Court Filed:	
Docket Number of Petition:	
Orders of Discharge:	

d. Do you have litigation funding where the funder has decision making authority over the terms of any settlement or other resolution of your claim? Yes/No [DROP DOWN]

If Yes, please state the following:

Name & Address of Third Party:	
Basis for Decision Making Authority:	

14. POTENTIAL FACT WITNESSES

a. Identify each person who you believe possesses information concerning the facts of your lawsuit, including your current medical conditions, other than your healthcare providers:

Name	Address	Relationship to You

15. DECEASED INDIVIDUALS & AUTOPSY INFORMATION

a. Are you filling this PFS out on behalf of an individual who is deceased and/or on whom an autopsy was performed? Yes/No [DROP DOWN]

If Yes, please state the following from the individual's Death Certificate and/or Autopsy Report:

[NOTE: In addition to the following, please attach a copy of the death certificate, the letters of administration, and a copy of the autopsy report (if applicable).]

Date of Death:	
Place of Death (city, state, and country):	
Facility/Location Where Death Occurred:	
Name of Physician Who Signed Death Certificate:	
Cause of Death Listed on the Certificate:	
Date of Autopsy:	
Name of Physician Who Performed Autopsy:	

16. AUTHORIZATIONS AND DOCUMENT DEMANDS

Plaintiff agrees to produce copies of signed and dated authorizations to the extent applicable at the time of service of this PFS for the releases listed below. Plaintiff agrees that any document request for records to be produced by plaintiff will not preclude defendant from also collecting such records directly from the source pursuant to the signed authorizations.

DOCUMENT DEMANDS

Produce copies of the following documents that are in your current possession and to the extent the documents are not subject to and protected by any claim of privilege:

1. Copies of all medical records from any physicians, hospital, or healthcare provider who has treated you for any condition, illness, and/or disease identified in response to this PFS.
2. Copies of all records from any healthcare provider identified in response to this PFS.
3. All radiographs (x-rays, ultrasounds, MRI's, CT scans, etc.) that relate to any of Plaintiff's joints, back, or spine, as well as any pre- and post-implant radiology for any organ to which Plaintiff makes a claim.
4. All documents and/or notices received by Plaintiff with respect to third party lienholders, including but not limited to, insurance companies, workers' compensation, Medicare/Medicaid, and/or other governmental entities.
5. Copies of advertisements, informational brochures, or promotions that you saw or reviewed prior to your implant surgery discussing implant surgery or implant components.

6. All documents regarding the health risks associated with your implant surgery at or before the time of injury alleged in your Complaint, other than documents prepared by your attorney in this action.

7. All document that you believe were provided to you (not by your lawyer) by any defendant.

8. All photographs or videos of Plaintiff's surgery(ies), all photographs or videos depicting the Exactech product(s) at issue, and representative photographs and videos of Plaintiff which show Plaintiff's condition since the date of the original implantation(s).

9. Any documents, including but not limited to, literature or warnings received by you from surgeons, physicians, or other healthcare professionals who have treated you for any condition related to the Exactech product(s).

10. Documents that relate in any way to your application for, or award of, workers' compensation benefits for any injury or condition related to your impacted joint during the period from ten (10) years before your first implant surgery to the present.

11. Copies of any accident report(s) related to any accident or event, in which or as a result of which you sustained any personal injuries to your legs, hips, spine, knees, ankles, or pelvic area for the ten (10) years before your first implant surgery to the present.

12. All bankruptcy petitions and orders of discharge (if applicable) for all bankruptcy claims made by you or your spouse/partner if he/she is a plaintiff since the date of your first implant surgery.

13. Copies of all pleadings and deposition transcripts in your possession or the possession of any attorney who represented you related to any lawsuit or claim against anyone related to any injury to your hip, pelvis, spine, or legs that are not subject to confidentiality requirements from a non-party.

14. If applicable, decedent's death certificate and copies of letters testamentary or letters of administration confirming standing of the named plaintiff.

AUTHORIZATIONS FOR RELEASE OF INFORMATION

In addition to producing records responsive to the above demands, the plaintiff who was implanted with the Exactech product(s) at issue is also required to complete and sign the below-referenced authorizations, if applicable, and as identified by the plaintiff in his/her responses to the Plaintiff Fact Sheet:

Authorization	**Attachment**	**Requirement**
Authorization to Disclose Protected Health Information (i.e., medical records)	A	To be signed by all plaintiffs.
Authorization for the Release of Adverse Event Reports	B	To be signed by all plaintiffs.
Authorization to Disclose Psychological Records/Psychotherapy Notes	C	To be signed *only if* a plaintiff is claiming psychological, emotional or mental health damages per Section 7 of the PFS *for reasons related to the Exactech product(s) at issue.*
Authorization to Disclose Employment Information	D	To be signed *only if* a plaintiff is claiming lost wages or loss of earning capacity per Section 8 of the PFS.
Authorization to Disclose Worker's Compensation Information	E	To be signed *only if* a plaintiff has filed for worker's compensation benefits per Section 14 of the PFS *for reasons related to the plaintiff's joint(s) at issue in this lawsuit.*
Request for Copy of Tax Return	F	To be signed *only if* a plaintiff is claiming lost wages or loss of earning capacity damages per Section 8 of the PFS.
Social Security Administration (SSA) Consent for Release of Information	G	To be signed *only if* a plaintiff has filed for a claim for disability benefits per Section 14 of the PFS.
Request for Social Security Earnings Information	H	To be signed *only if* a plaintiff is claiming lost wages or loss of earning capacity damages per Section 8 of the PFS.

DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry, that I have supplied all the documents requested in this Plaintiff Fact Sheet, to the extent that such documents are in my possession, and that I have supplied/will supply the Authorizations attached to this declaration, in accordance with the terms of this Plaintiff Fact Sheet.

_____ _____

Signature Date

_____

Print Name

17. LOSS OF CONSORTIUM PLAINTIFFS

a. State the following:

Your Name:	
Other Names and the Dates You Used Those Names:	
Did you live with the primary plaintiff at the time the alleged injury occurred? Y/N [Drop Down]	
Sex: M/F [Drop Down]	

b. Have you sustained a loss of consortium, care, services, companionship, counsel, advice, assistance, comfort, or any similar loss for which you contend that Exactech should pay you compensation? Yes/No [DROP DOWN]

If Yes, do you contend that you have sustained, or will you sustain in the future, a loss of wages or income attributable to your loss? Yes/No [DROP DOWN]

LOSS OF CONSORTIUM PLAINTIFF DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the information provided in Section 17 of this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information, and belief.

_____ _____

Signature Date

_____

Print Name

HIPAA COMPLIANT
AUTHORIZATION FROM INDIVIDUAL
FOR RELEASE OF MEDICAL RECORDS

Purpose: This form is used to confirm the direction of an individual that Provider use or disclose the individual's protected health information for a particular purpose.

SECTION A: The Individual (or the Individual's Personal Representative) confirming the authorization.

I authorize the use and/or disclosure of my protected health information as described in Section B below. I understand this authorization is voluntary and made to confirm my direction.

I understand that, if the persons or organizations I authorize below to receive and/or use the protected health information described below are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Name: _____

Address: _____

Telephone: _____ Date of Birth: _____

Social Security Number: _____ Purpose: **Legal**

SECTION B: The use and/or disclosure being authorized.

Protected Health Information to be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed

1. My patient file, including, but not limited to, patient history, office charts, progress notes, diagnostic test results, x-ray or laboratory reports, surgical reports, consultation reports, pathology reports, specimens and/or slides, correspondence, drug and alcohol testing and treatment, and any other document pertaining to me.
2. Any and all records relating to my medical treatment, including, but not limited to, documents relating to office visits, hospital visits, medical tests, and any medical, or surgical treatments.
3. Any and all x-rays, MRI's, CT scans, ultrasounds or other radiological or sonographic studies.
4. My billing file, including any charges and payments for office visits, procedures, hospital visits, laboratory tests, x-rays, medication, and any other treatment for which charges were incurred.

Entities Authorized to Use or Disclose: Name or specifically identify the persons or organizations (or the classes of persons and/or organizations), including Provider, who you are authorizing to make use of and/or to disclose the protected health information described above: This Authorization is voluntary. Pursuant to the Privacy Rules, the provider may not condition treatment, payment, or eligibility for benefits on whether the patient signs this authorization.

Medical records from _____, 20___ to present from:

_____

_____

_____

_____

Entities Authorized to Receive and Use: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing Provider to disclose and/or let use the protected health information described above:

Faegre Drinker Biddle & Reath LLP, Attorneys and/or Their Representatives
320 South Canal Street, Suite 3300
Chicago, IL 60606-5707
Telephone: (312) 569-1000
Facsimile: (312) 569-3000

SECTION C: Expiration and Revocation.

Expiration: This authorization will expire (complete one):

☐ On _____/_____/_____ (DD/MM/YR).

☒ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized: **At the conclusion of litigation between _____ v. Exactech, Inc., et al.**

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Faegre Drinker Biddle & Reath LLP

Telephone: (312) 569-1000 Fax: (312) 569-3000

Address: 320 South Canal Street, Suite 3300, Chicago, IL 60606

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under HIPAA privacy rules.

SIGNATURE.

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the Provider. I understand that, by signing this form, I am confirming my authorization that the Provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this authorization is signed by an individual's personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

AUTHORIZATION FOR THE RELEASE OF ADVERSE EVENT REPORTS PURSUANT TO 21 C.F.R. § 20.63

I, _____, hereby authorize and consent to the release of any and all Adverse Event reports relating to my medical condition(s) and care at issue, and with my name unredacted, including but not limited to, United States Food and Drug Administration Medical Device Reports and manufacturer-generated Issue Reports, to my counsel of record as indicated below:

NAME: _____

ADDRESS: _____

PHONE: _____

_____ _____

Signature of Individual or Representative Date

_____

Printed Name of Representative and Relationship to Individual (if applicable)

_____

Description of Representative's Authority (if applicable)

Form **SSA-7050-F4** (11-2022)
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-0525

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

*Use This Form If You Need

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

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

DO NOT USE THIS FORM TO REQUEST YEARLY EARNINGS TOTALS

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

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

Privacy Act Statement
Collection and Use of Personal Information

Section 205 of the Social Security Act, as amended, allows us to collect this information. In addition, the Budget and Accounting Act of 1950 and Debt Collection Act of 1982 authorize us to collect credit card information, if you choose to pay for the earnings information you have requested with a credit card. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from processing your request.

We will use the information to identify your records, process your request, and send the earnings information you request. We may also share the information for the following purposes, called routine uses:

1. To the Internal Revenue Service (IRS) for auditing SSA's compliance with the safeguard provisions of the Internal Revenue Code of 1986, as amended.

2. To contractors and other Federal agencies, as necessary, for the purpose of, assisting the Social Security Administration (SSA) in the efficient administration of its programs.

3. To banks enrolled in the Treasury credit card network to collect a payment or debt when the individual has given his/her credit card number for this purpose.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs) 60-0059, entitled Earnings Recording and Self-Employment Income System, 60-0090, entitled Master Beneficiary Record, 60-0224, entitled SSA-Initiated Personal Earnings and Benefit Estimate Statement, and 60-0231, entitled Financial Transactions of SSA Accounting and Finance Offices. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

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

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

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

First Name: Middle Initial:

Last Name:

Social Security Number (SSN) One SSN per request

Date of Birth: Date of Death:

Other Name(s) Used
Maiden Name

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

☐ **Itemized Statement of Earnings $100.00**
(Includes the names and addresses of employers)
If you check this box, tell us why you need this information below.

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

☐ Check this box if you want the earnings information **CERTIFIED** for an additional $44.00 fee.

☐ **Certified Yearly Totals of Earnings $44.00**
(Does not include the names and addresses of employers)Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

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

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

Name

Address | State

City | ZIP Code

4. I am the individual to whom the record pertains (or a person authorized to sign on behalf of that individual).
I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature AND Printed Name of Individual or Legal Guardian | *SSA must receive this form within 120 days from the date signed*
Date

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

Address | State

City | ZIP Code

Witnesses must sign this form ONLY if the above signature is by marked (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of Witness | 2. Signature of Witness

Address *(Number and Street, City, State and ZIP Code)* | Address *(Number and Street, City, State and ZIP Code)*

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

INFORMATION ABOUT YOUR REQUEST

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

How do I get my earnings statement?

You must complete the attached form. Tell us the specific years of earnings you want, type of earnings record, and provide your mailing address. The itemized statement of earnings will be mailed to ONE address, therefore, if you want the statement sent to someone other than yourself, provide their address in section 3. Mail the completed form to SSA within 120 days of signature. If you sign with an "X", your mark must be witnessed by two impartial persons who must provide their name and address in the spaces provided. Select **ONE** type of earnings statement and include the appropriate fee.

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

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

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

How do I get someone else's earnings statement?

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

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

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

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

Is There A Fee For Earnings Information?

Yes. We charge a $100.00 fee for providing information for purposes unrelated to the administration of our programs.

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

We will **certify** the itemized earnings information for an additional $44.00 fee. Certification is usually not necessary unless you are specifically requested to obtain a certified earnings record.

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

2. Certified Yearly Totals of Earnings
We charge $44.00 to certify yearly totals of earnings. However, if you do not want or need certification, you may obtain yearly totals *FREE* of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are advised specifically to obtain a certified earnings record.

Method of Payment
This Fee Is Not Refundable. DO NOT SEND CASH.

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

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

How long will it take SSA to process my request?

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

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

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

Mail the completed form, supporting documentation, and applicable fee to:	If using private contractor such as FedEx mail form, supporting documentation, and application fee to:
Social Security Administration P.O. Box 33011 Baltimore, Maryland 21290-33011	**Social Security Administration** P.O. Box 33011 Baltimore, Maryland 21290-33011

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

Non-Certified Itemized Statement of Earnings	**Certified** Itemized Statement of Earnings
$100.00	$144.00

- **How much do I have to pay for Certified Yearly Totals of Earnings?**

Certified yearly totals of earnings cost $44.00. You may obtain non-certified yearly totals FREE of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are specifically asked to obtain a certified earnings record.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

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

CHECK ONE	☐ Visa ☐ American Express ☐ MasterCard ☐ Discover
Credit Card Holder's Name (Enter the name from the credit card)	First Name, Middle Initial, Last Name
Credit Card Holder's Address	Number & Street City, State, & ZIP Code
Daytime Telephone Number	Area Code
Credit Card Number	
Credit Card Expiration Date	(MM/YY)
Amount Charged See above to select the correct fee for your request. Applicable fees are $44.00, $100.00, or $144.00. SSA will return forms without the appropriate fee.	$
Credit Card Holder's Signature	Date

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

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

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

NOTE: Do not use this form to:

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

How to Complete this Form

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

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

PRIVACY ACT STATEMENT

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

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

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

PAPERWORK REDUCTION ACT STATEMENT

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

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** ***ADDRESS OF PERSON OR ORGANIZATION:**

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Form **4506**

(Novmeber 2021)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

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

Caution: If the tax return is being sent to the third party, ensure that lines 5 through 7 are completed before signing. (see instructions).

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

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

7 **Year or period requested.** Enter the ending date of the tax year or period using the mm/dd/yyyy format (see instructions).

____/____/_____ ____/____/_____ ____/____/_____ ____/____/_____

____/____/_____ ____/____/_____ ____/____/_____ ____/____/_____

8	**Fee.** There is a $43 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.**	
a	Cost for each return	$ **43.00**
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☐

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

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) | Date

▶ Print/Type name | **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** | Date

▶ Print/Type name

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

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506*.

General Instructions

Caution: Do not sign this form unless all applicable lines, *including lines 5 through 7*, have been completed.

Designated Recipient Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information received pursuant to the taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

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

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

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

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

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Florida, Louisiana, Mississippi, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alabama, Arkansas, Delaware, Georgia, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, South Carolina, Tennessee, Vermont, Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maryland, Michigan, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, West Virginia, Wyoming	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Chart for all other returns

For returns not in Form 1040 series, if the address on the return was in:	Mail to:
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Specific Instructions

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

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

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

Note. If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B,Change of Address or Responsible Party — Business, with Form 4506.

Line 7. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 return, or 03/31/2017 for a first quarter Form 941 return.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, *including lines 5 through 7*, are completed before signing.

CAUTION *You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.*

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

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

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

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

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

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

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

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

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

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

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

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

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

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

AUTHORIZATION TO DISCLOSE EMPLOYMENT INFORMATION

To: _____
_____
_____
_____

I, _____, the undersigned, hereby authorize and request the above-named entity to disclose to Faegre Drinker Biddle & Reath LLP and/or their representatives, 320 South Canal Street, Suite 3300, Chicago, Illinois 60606, any and all records containing employment information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. Records requested may include, but are not limited to:

> All applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files; all hospital, physician, clinic, infirmary, nurse, dental records; test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; materials safety data sheets, chemical inventories and environmental monitoring records and all other employee exposure records pertaining to all positions held; and any other records concerning employment with the above-named entity. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information. By signing this authorization, I expressly do not authorize any ex parte interview or oral communication about me or my employment history by Faegre Drinker Biddle & Reath LLP without the presence of my attorney.

A photocopy of this authorization should be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of the pending litigation between _____ and Exactech, Inc.; or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation.

NOTICE:

- The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Faegre Drinker Biddle & Reath LLP, except to the extent that the entity has already relied upon this authorization to disclose protected health information (PHI).
- The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.
- The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.
- The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease;
- The individual signing this authorization understands that she/he shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by Faegre Drinker Biddle & Reath LLP.

I have read this authorization and understand that it will permit the entity identified above to disclose PHI to Faegre Drinker Biddle & Reath LLP.

_____	_____
Name of Employee	Signature of Employee or Employee Representative
_____	_____
Former/Alias/Maiden Name of Employee	Date
_____	_____
Employee's Date of Birth	Name of Employee Representative
_____	_____
Employee's Social Security Number	Description of Authority
_____	_____
Employee's Address	

AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION INFORMATION

To: _____
_____
_____
_____

I, _____, the undersigned, hereby authorize and request the above-named entity to disclose to Faegre Drinker Biddle & Reath LLP and/or their representatives, 320 South Canal Street, Suite 3300, Chicago, Illinois 60606, any and all records containing Workers' Compensation information, including those that may contain protected health information (PHI) regarding _____, whether created before or after the date of signature. Records requested may include, but are not limited to:

> All Workers' Compensation claims, including claim petitions, judgments, findings, notices of hearings, hearing records, transcripts, decisions and orders; all depositions and reports of witnesses and expert witnesses; employer's accident reports; all other accident, injury, or incident reports; all medical records; records of compensation payment made; investigatory reports and records; applications for employment; records of all positions held; job descriptions of any positions held; salary records; performance evaluations and reports; statements and comments of fellow employees; attendance records; all physicians', hospital, medical, health reports; physical examinations; records relating to health or disability insurance claims, including correspondence, reports, claim forms, questionnaires, records of payments made to physicians, hospitals, and health institutions or professionals; statements of account, itemized bills or invoices; and any other records relating to the above-named individual. Copies, NOT originals, of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of _____ (DOB) to present.

Because this litigation is ongoing, it is imperative that you preserve the original workers' compensation records. Please take all steps necessary to preserve the workers' compensation records that remain in your possession.

A photocopy of this authorization should be considered as effective and valid as the original, and this authorization will remain in effect until the earlier of: (i) the date of settlement or final disposition of the pending litigation between _____ and Exactech, Inc.; or (ii) five (5) years after the date of signature of the undersigned below. The purpose of this authorization is for civil litigation.

NOTICE:

- The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Faegre Drinker Biddle & Reath LLP, except to the extent that the entity has already relied upon this authorization to disclose protected health information (PHI).
- The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.
- The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.
- The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease;
- The individual signing this authorization understands that she/he shall be entitled to receive a copy of all documents requested via this authorization within a reasonable period of time after such records are received by Faegre Drinker Biddle & Reath LLP.

I have read this authorization and understand that it will permit the entity identified above to disclose PHI to Faegre Drinker Biddle & Reath LLP.

_____	_____
Name of Employee	Signature of Employee or Employee Representative
_____	_____
Former/Alias/Maiden Name of Employee	Date
_____	_____
Employee's Date of Birth	Name of Employee Representative
_____	_____
Employee's Social Security Number	Description of Authority
_____	_____
Employee's Address	