IN RE: TASIGNA PRODUCTS LIABILITY LITIGATION

SUPERIOR COURT OF NEW JERSEY

LAW DIVISION: BERGEN COUNTY
CASE NO. 635
MASTER DOCKET NO.: BER-L-5018-21

CIVIL ACTION

CASE MANAGEMENT ORDER #3

FILED
FEB 02 2022
RACHELLE L. HARZ
J.S.C.

PLAINTIFF FACT SHEET

THIS MATTER having been assigned to the Honorable Rachelle L. Harz, J.S.C., pursuant to the Supreme Court's Order of April 6, 2021, designating this matter for Multicounty Litigation ("MCL") status, for the reasons set forth on the record and good cause shown,

IT IS on this 2nd day of February, 2022, **ORDERED**:

A. Plaintiff Fact Sheet, Authorizations and Responsive Documents

1. The Honorable Roy B. Dalton Jr., U.S.D.J., on November 2, 2021, entered a Plaintiff Fact Sheet ("PFS") that includes document requests in Section IX and a variety of Authorizations. In the interest of continuing combined coordination of all discovery in the MDL and this MCL, this court is implementing the aforementioned order of Judge Dalton in this MCL pertaining to Plaintiff Fact Sheet. Each plaintiff shall produce to Defendant a completed PFS, executed Authorizations, and documents responsive to Section IX of the PFS ("Responsive Documents") pursuant to the terms of this Order, attached to the Plaintiff Fact Sheet as Exhibits 1 through 6.

2. A completed PFS, which requires that each plaintiff sign the accompanying Declaration, shall be considered interrogatory answers pursuant to Rule 4:17 and responses to requests for production pursuant to Rule 4:18, and it will be governed by the standards applicable to written discovery under the New Jersey Court Rules. The PFS shall be timely supplemented. As

set forth below in Section C, each PFS must be substantially complete. All objections to the admissibility of information contained in the PFS are reserved, and therefore no objections shall be lodged in the response to the questions and document requests contained in the PFS.

3. Nothing in this section prohibits a Plaintiff from withholding or redacting information based upon a recognized privilege. If information is withheld or redacted on the basis of privilege, that Plaintiff shall provide Defendant with a privilege log.

4. Nothing in the PFS shall be deemed to limit the scope of inquiry at depositions and admissibility of evidence at trial. The scope of inquiry at depositions shall remain governed by the New Jersey Court Rules. The admissibility of information in responses to the PFS shall be governed by the New Jersey Rules of Evidence and no objections to admissibility are waived by virtue of any PFS response.

B. Schedule of PFS Production

1. Each Plaintiff whose case is docketed in this MCL as of the date of entry of this Order shall produce to Defendant a completed PFS, executed Authorizations, and Responsive Documents. Each PFS, along with the executed Authorizations and Responsive Documents, is to be served on a rolling basis as follows: (1) one-third of the PFSes are due sixty (60) days from the date of entry of this Order; (2) an additional one-third of the PFSes are due ninety (90) days from the date of entry of this order; and (3) all remaining PFSes are due 120 days from the date of entry of this Order. Each Plaintiff whose case is docketed in this MCL after the date of entry of this Order shall have sixty (60) days from the date that service of the complaint is made on the Defendant in this MCL to produce a completed PFS, executed Authorizations, and Responsive Documents.

2. Service of the PFS and accompanying materials shall be submitted by email to: TasignaStatePFS@Hollingsworthllp.com.

C. Each PFS Must Be Substantially Complete

1. Each Plaintiff is required to provide Defendant with a PFS that is substantially complete in all respects. In order to be substantially complete in all respects, each Plaintiff is required to:

a. Answer all questions in the PFS leaving none blank. A plaintiff may answer questions in good faith by indicating "Not Applicable" or "I don't know" or "Unknown";

b. Include a signed Declaration;

c. Produce duly executed record release Authorizations; and

d. Produce the documents requested in the PFS, to the extent such documents are in the Plaintiff's possession, custody, or control.

2. Failure to satisfy any requirement of this section shall represent a material deficiency in the PFS and subject that Plaintiff's case to potential dismissal with prejudice as set forth in Section F herein.

3. The Court reminds Defendant that any perceived deficiency in the PFS is not sufficient reason to withhold production of the Defendant Fact Sheet ("DFS"). The Court reminds Plaintiffs that it expects each PFS to be substantially complete. Any perceived deficiencies should be brought to the Court's attention immediately via a joint submission.

D. Authorizations for the Release of Records

1. As set forth above, Authorizations for the Release of Records shall be provided, completed in full but for the date, along with the PFS at the time that the Plaintiff is required to serve a PFS pursuant to this Order.

2. Authorizations shall be executed "in blank" (that is, without setting forth the identity of the custodian of records or provider of care). Defendant and its record copy vender, Strategic Litigation Partners ("SLP"), may address such Authorizations and use them to obtain records for Healthcare Providers and other sources of records (for example, pharmacies, employers, and the like).

3. Defendant and SLP are permitted to date Authorizations before sending to records custodians for healthcare providers or other entities that require Authorizations.

4. In the event that a signed Authorization does not contain the following information with respect to the Plaintiff—or, in the case of an Authorization signed in a representative capacity, the information with respect to the represented party—Defendant and SLP are authorized to fill in the following information:

a. The name and/or address of the Plaintiff, or represented party, at the top of the Authorization;

b. The Social Security Number of the Plaintiff or represented party;

c. The date of birth of the Plaintiff or represented party;

d. The name of defense counsel or SLP as the party to whom records may be released.

5. In the event that an institution or medical provider to whom any Authorization is presented refuses to provide records in response to that Authorization, Defendant shall notify the Plaintiff's individual representative counsel. Should a particular additional or alternative form be required, Defendant will provide it to the Plaintiff's individual representative counsel. The individual Plaintiff shall execute and return any form required by that institution or provider within thirty (30) days.

6. Defendant's record copy service vendor shall have the right to contact institutions or medical providers to follow up on medical record copying or production.

E. Non-Compliance with PFS Requirements

Any Plaintiff who fails to comply with their PFS obligations under Section C of this Order may be subject to having their claims, as well as any derivative claim(s), dismissed. If a Plaintiff fails to provide a PFS within the time allotted or provides a PFS that is not substantially complete in all material respects, Defendant will send a Notice of Overdue Discovery ("Delinquency Letter") or Notice of Incomplete Discovery ("Deficiency Letter") to that Plaintiff's counsel identifying the discovery overdue and/or the material deficiency. The Plaintiff shall have thirty (30) days after receiving a Delinquency Letter or Deficiency Letter to submit the PFS or cure the alleged deficiency. If that Plaintiff has not provided a completed PFS and/or cured the material deficiency within thirty (30) days after receiving a Delinquency Letter or Deficiency Letter, after meeting and conferring with the Plaintiff's counsel, Defendant may move the Court for an Order dismissing the Complaint without prejudice. The Plaintiff shall have fourteen (14) days from the date of Defendant's motion to file a response either certifying that the Plaintiff has served upon Defendant and Defendant has received a completed PFS and attaching appropriate documentation

of receipt, or to file an opposition to Defendant's motion. If a Plaintiff fails to file a notice or opposition, an Order dismissing the case without prejudice will be entered at the Court's discretion. Unless the Plaintiff has served Defendant with a completed PFS within thirty (30) days after entry of any such Order of Dismissal without prejudice, the Order may be converted to a Dismissal with Prejudice upon Defendant's motion, at the Court's discretion.

If additional time is needed in a specific case for good cause, the parties will meet and confer in good faith to resolve any issues.

The parties are reminded that all motions made pursuant to this Section are subject to meet and confer requirements.

F. Copies of Records

Defendant or its designee(s) shall make available all records obtained by use of Authorizations to the attorney or record for each individual Plaintiff within thirty (30) days of the receipt of the records.

G. Obligation of PFS

Nothing herein shall preclude the parties from serving reasonable case-specific discovery requests in connection with individual cases that have been identified for trial work-up/bellwether process by the Court, and the parties will meet and confer to discuss the scope of such discovery and raise any areas of dispute with the Court.

Dated: 2/2, 2022

Judge Rachelle Lea Harz, J.S.C.

IN RE: TASIGNA PRODUCTS LIABILITY LITIGATION

SUPERIOR COURT OF NEW JERSEY

LAW DIVISION: BERGEN COUNTY
CASE NO. 635
MASTER DOCKET NO.: BER-L -5018-21

CIVIL ACTION

PLAINTIFF FACT SHEET

INSTRUCTIONS

Please provide the following information regarding yourself or each individual on whose behalf you are making a claim. Each question must be answered to the best of your knowledge. If you do not know or cannot recall the information needed to answer a question, please state so explicitly in response to the question. Do not leave any questions unanswered or blank. In filling out this form, please use the following definitions:

1. **"You"** or **"Your"** refers to the person who used Tasigna®, unless otherwise specified.

2. **"Health care provider"** or **"health care practitioner"** means the following:

   a. Any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, psychiatric, mental, or psychological care or advice.

   b. Any doctor, physician, or surgeon—including, but not limited to, any oncologist, radiologist, pathologist, cardiologist, cardiac surgeon, vascular specialist, vascular surgeon, phlebologist, vein specialist, or osteopath—and any natural health provider, homeopath, paramedic, nurse (registered or otherwise), physiotherapist, physical therapist, massage therapist, acupuncturist, psychologist, psychiatrist, or therapist.

3. **"Document"** means any writing or record of every type that is in your possession, custody, or control or that of your counsel, including but not limited to written documents, cassettes, videotapes, photographs, charts, computer discs or tapes, x-rays, drawings, graphs, phonorecords, nonidentical copies and other data compilations from which information can be obtained and, if necessary, translated by the plaintiff into reasonably usable form. For the purposes of this fact sheet, the term "Document" shall not include electronically stored information.

You may attach as many sheets of paper as necessary to answer these questions fully. If you have any documents—including, but not limited to, packaging, instructions, or other materials that you are required to produce in response to questions in this Fact Sheet or that relate to Tasigna®, or to the incident, injuries, claims, or damages that are the subject of your complaint—**you must not** dispose of, alter, or modify those documents or materials in any way. You are also required to give all of those documents and materials to your attorney as soon as possible. If you are unclear about these obligations, please contact your attorney.

I. CASE INFORMATION

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

1. Your name: _____
2. Address: _____

   _____
3. In what capacity are you representing the individual? _____

   _____

If you were appointed by a court, please provide a copy of the order of appointment. If you were named a representative other than by court appointment, attach documentation demonstrating your entitlement to be a representative.

If you are completing this questionnaire in a representative capacity, please respond to the remaining questions on behalf of the person who used Tasigna®. Any questions using the term "You" refer to the person who used Tasigna®. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.

II. PERSONAL INFORMATION

A. Last name: _____
First name: _____
Middle name or initial: _____
Maiden name (if any): _____
Other names, if any, by which you have been known (from prior marriages or otherwise): _____

B. Gender: Male _____ Female _____

C. Social Security number: _____

D. Date and place of birth: _____

E. Identify each home address where you have lived during the last ten (10) years, including time periods of residence, and persons, if any, who lived with you:

Prior Address	Approximate Dates You Lived at Address	Persons, If Any, Who Lived with You at Address

[Attach additional sheets as necessary]

F. Please identify every place where you have been employed for a minimum of three (3) months for the period beginning five (5) years prior to your CML diagnosis, including any periods of self-employment If you are making a claim for lost wages or lost earning capacity, please also provide your salary, annual gross compensation and/or other compensation received:

Employer Name	Employer Address	Approximate Dates of Employment	Title or Occupation	Annual Salary or Wages (if claiming lost wages)	Overtime or Bonus Wages

[Attach additional sheets as necessary]

G. Have you ever been discharged from military service for any reason relating to your medical, physical, psychiatric, or emotional condition?

Yes _____ No _____

If yes, state what the condition was and who diagnosed it: _____

_____

_____

H. Have you ever been rejected from military service for any reason relating to your medical, physical, psychiatric, or emotional condition?

Yes _____ No _____

If yes, state the reason(s) you were rejected from military service: _____

_____

I. Have you filed a worker's compensation claim in the last ten (10) years?

Yes _____ No _____

If yes, please state:

1. Year the claim was filed: _____
2. Company and/or court where the claim was filed: _____

_____

3. Nature of the injury or disability claimed: _____
   _____
4. Amount awarded?_____
5. Period of disability?_____

[If you filed multiple claims, please copy and complete this question for each]

J. Have you filed a Social Security or other disability claim in the last ten (10) years?

Yes _____ No _____

If yes, please state:

1. Year the claim was filed: _____
2. Company and/or court where the claim was filed: _____
   _____
3. Nature of the injury or disability claimed: _____
   _____
4. Amount awarded?_____
5. Period of disability?_____

[If you filed multiple claims, please copy and complete this question for each]

K. Have you ever been denied life insurance for reasons relating to your cardiovascular health?

Yes _____ No _____

If yes, please state when, the name of the company, and the company's stated reason(s) for denial: _____
_____

[Attach additional sheets as necessary]

L. Have you ever been denied medical insurance for reasons relating to your cardiovascular health?

Yes _____ No _____

If yes, please state when, the name of the company, and the company's stated reason(s) for denial: _____
_____

M. Have you ever brought a personal injury lawsuit against anyone, aside from the present suit?

Yes _____ No _____

If yes, for each such lawsuit, please state:

a. When and where the lawsuit was filed: _____

_____

b. Case number: _____

c. Nature of the claims in the lawsuit: _____

_____

d. Outcome: _____

[Attach additional sheets as necessary]

N. Have you ever missed work for more than thirty (30) days for reasons related to your cardiovascular health?

Yes _____ No _____

If yes, please state the approximate dates, employer, and health condition: _____

_____

_____

O. Identify all social/professional networking websites with which you have been register registered for the period beginning five (5) years prior to your use of Tasigna® through the present, including usernames and the approximate range of dates of use for each (this includes, but is not limited to, Facebook, Twitter, MySpace, Linkedin, Instagram, TikTok, Reddit, Quora, Digg, Pinterest, Snapchat, Google+, Tumblr, YouTube, Facebook Live, Periscope, Vimeo, Flipboard):

Social/Professional Networking Website	Username(s)	Approximate Dates of Use

P. Have you ever been married?

Yes _____ No _____

If **yes**, for each spouse/former spouse state:

1. Spouse's name: _____
2. Approximate dates of marriage: _____

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

_____

Q. Identify (1) each secondary/high school, college, university, or trade school, you have attended in your lifetime, (2) the approximate dates of attendance, and (3) diplomas, degrees, or certificates of completion awarded:

Name of School	Approximate Dates of Attendance	Diploma, Degree, or Certificate of Completion Awarded

III. TASIGNA® USE

A. Provide the following information concerning your use of Tasigna®:

Approximate Dates of Tasigna® Use	Physician(s) who prescribed Tasigna®	Address, and Specialty of the Prescribing Physician(s)

B. Were you given any oral or written warnings or instructions, regarding Tasigna®, including any packaging, package inserts, pamphlets, or brochures **before** you received Tasigna®?

Yes _____ No _____ I do not recall _____

1. **If yes**, please provide the name, address, and specialty of the person who gave you the instructions or warnings. _____

_____

_____

2. **If yes**, what were the warnings or instructions. _____
_____
_____

3. Do you still have this information? **If yes**, attach it to your responses.

Yes _____ No_____

C. Who prescribed Tasigna® for you (provide name, address and specialty)? _____
_____
_____

1. Did the physician(s) who prescribed Tasigna® explain to you the reasons why it was prescribed? _____
_____

2. What did they tell you? _____
_____
_____

[Attach additional sheets as necessary]

D. Have you ever seen or received any advertising materials regarding the promotion of Tasigna®?

Yes _____ No _____ I do not recall _____

1. **If yes**, approximately when and where did you see this material? _____
_____

2. Describe the advertising you saw: _____
_____
_____

E. To your knowledge, have you ever had any communications with Novartis Pharmaceuticals Corporation ("NPC") or their representatives regarding Tasigna®?

Yes _____ No _____

If yes, please describe the communication: _____
_____
_____

F. To the best of your knowledge, has anyone else—including any of your physicians, family members, or others—ever contacted NPC on your behalf about Tasigna®?

Yes _____ No _____

If yes, provide each person's name and address._____

_____

_____

G. Have you ever visited any website (including any social/professional networking websites) regarding Tasigna®?

Yes _____ No _____

If yes, identify all websites visited and approximate dates of visit: _____

_____

IV. CLAIMED INJURIES

A. Please identify the injuries you are seeking damages for as a result of your use of Tasigna®, both physical and psychological (if applicable):

1. Full description of injury: _____

_____

_____

2. Do you still have that injury or illness?

Yes _____ No _____

3. On what date did symptoms of that injury first appear? _____

_____

B. Have you had discussions with any treating health care provider(s) about whether your injury is related to the use of Tasigna®?

Yes _____ No _____

If yes, please identify:

Name of doctor: _____
Address: _____
Specialty: _____
Approximate Date of Discussion(s): _____
Please summarize the discussion(s): _____

_____

_____

[Attach additional sheets as necessary]

C. If you are making a claim for present or past psychological or emotional injury as a consequence of using Tasigna®, please summarize your claim. _____

_____

1. Do you still have that injury or illness?

   Yes _____ No _____

2. When did the symptoms first appear? _____

   _____

   _____

3. Have you received treatment for this injury? _____

4. **If yes**, when did you first contact a doctor or healthcare professional concerning this injury? _____

   _____

5. Who did you contact first (provide the name, address, and specialty of the physician)? _____

   _____

V. ECONOMIC DAMAGES

A. Are you making a claim for lost wages or earning capacity?

Yes _____ No _____ **If no, skip to Section VI.**

B. State the total amount of time that you have missed from work as a result of the injuries you claim are related to your use of Tasigna®.

Approximate time lost: _____
Approximate income lost: $_____

C. Are you seeking recovery for any out-of-pocket expenses associated with any health condition(s) you claim are related to your use of Tasigna®?

Yes _____ No _____

If yes, please identify and itemize all out-of-pocket expenses: _____

_____

VI. MEDICAL BACKGROUND

A. Height: _____
State your weight at the following times:
Weight at the time you started taking Tasigna®: _____
Current weight: _____

B. Please provide the name, address, specialty, and approximated dates of care for each physician or healthcare practitioner whom you have consulted, seen, or are currently seeing for examination, evaluation, diagnosis, or treatment of any condition, injury,

physical infirmity, disability, sickness, ailment, or affliction for the period beginning five (5) years prior to your CML diagnosis through the present (Novartis Pharmaceuticals Corporation ("NPC") reserves its right to seek information dating further back in time as needed on a case-specific basis):

Name of Doctor and Institution	Address	Condition(s) Treated	Approximate Dates of Care

[Attach additional sheets as necessary]

C. Please provide the following information with respect to your diagnosis for Chronic Myeloid Leukemia:

1. Date you were diagnosed with Chronic Myeloid Leukemia: _____
   _____
2. Identify which healthcare professionals listed in VI.B. above diagnosed you with, or treated you for, Chronic Myeloid Leukemia: _____
   _____
   _____
3. Please complete the following with regard to medication(s), other than Tasigna®, prescribed to treat your Chronic Myeloid Leukemia:

Medication(s)	Prescribing Physician(s)	Approximate Dates of Use

[Attach additional sheets as necessary]

4. Has any health care professional ever informed you that you have achieved a Major Molecular Response ("MMR")?

   Yes _____ No _____ Unknown_____

   If yes, please identify the approximate date and health care professional who told you were in MMR (provide the name and address of each physician): _____

   _____

   _____

5. Has any health care professional ever informed you that you have achieved a Treatment-Free Remission ("TFR")?

   Yes _____ No _____ Unknown_____

   If yes, please identify the approximate date and health care professional who told you were in TFR (provide the name and address of each physician): _____

   _____

   _____

D. Have you participated in any clinical trials or taken any experimental drugs for treatment of your Chronic Myeloid Leukemia?

   Yes _____ No _____

   If yes, please indicate when you participated in such trials, where the trials took place, and which drugs you took. _____

   _____

   _____

E. Have you ever experienced or been diagnosed with any of the following?

	Yes	**No**	**I do not know.**
Acute Coronary Syndrome			
Atherosclerosis			
Blood Clot			
Cancer (other than CML)			
Cardiac Arrhythmia			
Cardiovascular Disease			
Chronic Kidney Disease			

	Yes	No	I do not know.
Coronary Artery Disease			
Diabetes			
Heart Attack / Myocardial Infarction			
Heart Disease			
High Blood Pressure			
High Blood Cholesterol and/or Triglycerides			
Hyperthyroidism and/or Hypothyroidism			
Peripheral Artery Disease			
Peripheral Vascular Disease			
Stroke			

F. For each of the conditions you answered "Yes" to in section VI.E. above, please provide the following:

Condition	Healthcare Provider that Diagnosed or Treated You	Healthcare Provider's Address	Brief Description of Treatment Provided (Including any Medication(s) Prescribed)	Approximate Dates of Treatment/Dates of Prescription(s)

*The types of medications you should include in this table include but are not limited to:

Anticoagulants (blood thinners)
Antiplatelet medications
ACE inhibitors
Angiotensin II receptor blockers

Angiotensin receptor-neprilysin inhibitors
Beta blockers
Calcium channel blockers Cholesterol-lowering medications
Diuretics Vasodilators

[Attach additional sheets as necessary]

G. To the best of your knowledge, state whether you underwent any of the following tests, procedures, or surgeries **before** the injury you allege you suffered occurred:

	Yes	No
Ablation		
Angiogram		
Angioplasty		
Atherectomy		
Bypass Surgery		
Endarterectomy		
Organ Transplant		
Sclerotherapy		
Stent Placement		
Transmyocardial Revascularization ("TMR")		
Pacemaker		

H. For each test, procedure, or surgery for which you answered **"yes"** above, please identify the treating physician and approximate date of the test, procedure, or surgery.

Procedure	Treating Physician	Approximate Date

[Attach additional sheets as necessary]

VII. TOBACCO AND ALCOHOL USE

A. Tobacco Use History

1. Smoking Status (including cigarettes, cigars, pipe tobacco, and vapes) (check applicable):

   Current Smoker _____ Past Smoker _____ Non-Smoker _____

2. If you checked "Current Smoker" or "Past Smoker". Please identify the tobacco product(s) you have smoked (check applicable):

Cigarettes _____ Cigars _____ Pipe Tobacco _____ Vapes _____ Other _____

If Other, please specify: _____

3. If you checked "Current Smoker" how much do you smoke and for how many years?

   _____ packs/cigarettes/cigars/pipes (circle one) per day for _____ years

4. If you checked "Past Smoker", how much did you smoke and approximately what dates did you start and stop smoking?

   _____ packs/cigarettes/cigars/pipes (circle one) per day from _____ to _____

5. Do you currently use, or have you ever used, any other products containing nicotine not identified in the questions above (for example, nicotine gum)?

   Yes _____ No _____

   If yes, please state:
   a. Type of product: _____
   b. Quantity/frequency of use: _____
   c. Time period of use: _____

6. Do you currently live with, or have you ever lived with, anyone who smokes tobacco?

   Yes _____ No _____

   If yes, please state:
   a. Name of tobacco user and relationship to you: _____
      _____
   b. Type of tobacco product: _____
   c. Approximate quantity and frequency of use in your presence: _____
      _____
   d. Approximate dates of use: _____

B. Alcohol History

1. Do you currently drink alcohol (beer, wine, whiskey, etc.)?

   Yes _____ No _____

   If yes, check which represents your current alcohol consumption:
   _____ 1-5 drinks per week
   _____ 6-10 drinks per week
   _____ 11-14 drinks per week
   _____ 15 or more drinks per week

_____ Other (Describe: _____)

2. Have you consumed alcohol (beer, wine, whiskey, etc.) in the period of five (5) years prior to your CML diagnosis through present?

Yes _____ No _____

If yes, please check which represents your greatest alcohol consumption over an extended period (six (6) months or greater) within the period of five (5) years prior to your CML diagnosis through present:

_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 11-14 drinks per week
_____ 15 or more drinks per week
_____ Other (Describe: _____)

VIII. FACT WITNESSES

A. Please identify all persons, other than your healthcare providers, you believe possess information concerning your injury and/or your current medical condition, and for each person provide the following:

Name	Address	Description of Information You Believe They Possess

IX. DOCUMENTS

Please attach the following documents to this declaration, to the extent that such documents are currently in your possession, custody, or control or that of your lawyers. You are not required to produce documents that you have already produced to NPC.

A. Produce a signed copy of the release form attached as Ex. 1, leaving blank the name to whom the release is directed, authorizing NPC to obtain medical records from each health care practitioner, hospital, clinic, or any other facility or health care provider who later becomes known to NPC who has examined you, treated you, or consulted with other health care practitioners regarding your medical or mental condition at any time. Plaintiff will provide one blank authorization with the understanding that it will be duplicated to send to other doctors and/or institutions. In the instance that an institution-specific authorization or wet-ink signature is required, plaintiff agrees to provide it within 30 days of the request.

B. For each health care practitioner who has examined you, treated you, or consulted with other health care practitioners regarding your medical or mental condition at any time, at or in affiliation with a Veteran's Administration facility, produce an executed copy of the release form attached as Ex. 1, authorizing NPC to obtain medical records from each health care practitioner.

C. If you are claiming psychological, psychiatric, or emotional injuries. For each psychologist, psychiatrist or other mental health care practitioner who has examined or treated you for any psychological, psychiatric, or emotional injuries, illnesses and/or conditions allegedly suffered as a result of your treatment with Tasigna®, produce an executed copy of the release form attached as Ex. 2, authorizing NPC to obtain your psychotherapy notes generated by any such mental health care practitioner.

D. A copy of all medical records from any health care provider who treated you for any disease, condition, or symptom referred to in any or your responses to the questions above.

E. If you have been the claimant or subject of any worker's compensation, Social Security, or other disability proceeding, all documents relating to such proceeding(s).

F. Produce executed copies of each of the authorizations, attached as Ex. 3, authorizing NPC to obtain all documents discussing, describing or memorializing your requests for Social Security, disability insurance, or workers' compensation benefits, if applicable.

G. If you claim you have suffered a loss of earnings or earning capacity, produce your federal tax returns for each of the years from the period beginning five (5) years prior to your CML diagnosis to the present.

H. If you claim you have suffered a loss of earnings or earning capacity, produce executed copies of each of the authorizations, attached as Ex. 4, authorizing NPC to obtain your Federal and State income tax returns for each of the five (5) years prior to your CML diagnosis to the present.

I. For all past and present employers identified herein, produce two executed copies of the release form attached as Ex. 5, permitting NPC to obtain your employment records, including W-2 forms.

J. If you have served in the military, produce an executed copy of the release form attached as Ex. 6, permitting NPC to obtain your military personnel, service, and health records.

K. Copies of all documents from any healthcare provider (as defined above) or others discussing, describing, relating to, or memorializing your treatment with Tasigna® or to any condition you claim is related to the use of Tasigna®.

L. All documents relating to product use instructions, product warnings, package inserts, handouts, or other materials distributed with or provided to you in connection with your use of Tasigna®.

M. All photographs, drawings, journals, slides, or videos relating to your alleged injury.

N. Any diary, calendar, notes, letters, personal journals, or any other writing or recording made by you, or by any other person, describing, discussing, explaining or referring to the injuries, damages, or causes of action alleged by you in the Complaint.

O. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy, or other health care provider.

P. Decedent's death certificate (if applicable).

DECLARATION

I declare under penalty of perjury that all of the information provided in connection with this Plaintiff's Fact Sheet is true and correct to the best of my knowledge, information and belief at the present time. I further acknowledge that I have an obligation to supplement the above responses if I become aware of additional responsive information, or if I learn that they are in some material respects incomplete or incorrect.

_____ _____

Signature Date

EXHIBIT 1

AUTHORIZED IN CONNECTION WITH

In Re: Tasigna Products Liability Litigation,
Docket No.: BER-L-5018-21 (N.J. Super. Ct.)

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
In Compliance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164

To: _____
Name of Entity

_____
Address

_____
City, State, Zip Code

Re: _____
Name of Patient **Date of Birth** **Social Security No.**

I, the undersigned, or my authorized representative, subject to the conditions herein, hereby authorize and request the Custodian/Provider above-named to disclose to the agents or designees of the law firm of Hollingsworth, LLP and/or its agent, Strategic Litigation Partners, LP, any and all records, whether created before or after the date of signature, including but not limited to:

My entire medical record file, including but not limited to medical records, medical history or examination reports and notes, laboratory reports, pathology slides, reports, notes and specimen, radiographic films, CT scans, X-rays, MRI films/scans, MRA films/scans, correspondence, progress notes, prescription records, echocardiographic recordings, diagnostic testing, written statements, visits records, employment records, wage records, insurance, Medicare, Medicaid, disability records, medical bills/payment history, and email correspondence regarding my injuries, diseases, diagnoses, or treatment, whether generated by

you or provided to you by another entity, to include all archived records, records in storage, and all items as may be stored in a computer database or in electronic form or in paper form.

1. To my medical provider: This authorization is being forwarded by, or on behalf of, Hollingsworth, LLP, attorneys for the defendant, Novartis Pharmaceutical Corporation (Defendant). You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or medical or physical condition. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at deposition or trial.
2. I understand that the information in my health record may include information relating to alcohol/drug treatment, psychiatric, behavioral, mental health services, chemical or alcohol dependency, laboratory test results, communicable diseases, non-communicable diseases, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), or any other medical treatment.
3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expires at the end of the civil litigation.
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility benefits. I understand I may inspect or copy the information to be used or disclosed as provided in CFR §164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.
5. A notarized signature is not required. A copy of this authorization may be used in place of an original. Photocopies, facsimile transmittals, or other

electronically transmitted digital images of this authorization will be considered valid as if an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.
7. The individual signing this authorization expressly authorizes the above-named entity to disclose protected healthcare information described above to Hollingsworth LLP and/or Strategic Litigation Partners, LP, and authorizes re-disclosure of said records and information to consultants, experts, agents, and/or other counsel in this litigation.

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: Strategic Litigation Partners, LP; 21324 Provincial Blvd, Katy, TX 77450 as agent for Hollingsworth, LLP.

Date:_____ _____

Patient/Representative Signature
[Print name if not Patient]

Date:_____ _____

Witness Signature

EXHIBIT 2

AUTHORIZED IN CONNECTION WITH

In Re: Tasigna Products Liability Litigation,
Docket No.: BER-L-5018-21 (N.J. Super. Ct.)

LIMITED AUTHORIZATION TO DISCLOSE
PSYCHIATRIC, PSYCHOLOGICAL AND/OR MENTAL HEALTH TREATMENT, PSYCHOTHERAPY NOTES/RECORDS

In Compliance With the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164

To: _____
Name of Entity

_____
Address

_____
City, State, Zip Code

Re: _____
Name of Patient Date of Birth Social Security No.

This will authorize you to furnish copies of the following records and/or information as follows:

All "psychotherapy notes," as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's record. This authorization does not authorize ex parte communication concerning same. To include all archived records, records in storage, and all items as may be stored in a computer database or in electronic form.

1. To my medical provider: This authorization is being forwarded by, or on behalf of, Hollingsworth, LLP, attorneys for the defendant, Novartis Pharmaceutical Corporation (Defendant). You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or medical or physical condition. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at deposition or trial.
2. I understand that the information in my health record may include information relating to alcohol/drug treatment, psychiatric, behavioral, mental health services, chemical or alcohol dependency, laboratory test results, communicable diseases, non-communicable diseases, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), or any other medical treatment.
3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility benefits. I understand I may inspect or copy the information to be used or disclosed as provided in CFR §164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.
5. A notarized signature is not required. A copy of this authorization may be used in place of an original.
6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. The individual signing this authorization expressly authorizes the above-named entity to disclose psychiatric records and psychotherapy notes and information to Hollingsworth LLP and/or Strategic Litigation Partners, LP, and authorizes re-disclosure of said records and information to consultants, experts, agents, and/or other counsel in this litigation.

You are authorized to release the above records to the following representatives of defendants, who have agreed to pay reasonable charges made by you to supply copies of such records: Strategic Litigation Partners, LP; 21324 Provincial Blvd, Katy, TX 77450 as agent for Hollingsworth, LLP.

Date:_____

_____
Patient/Representative Signature
[Print name if not Patient]

Date:_____

_____
Witness Signature

EXHIBIT 3

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

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

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

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

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

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

REQUEST FOR SOCIAL SECURITY 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 $91.00**
(Includes the names and addresses of employers)
If you check this box, tell us why you need this information below.
Litigation

Year(s) Requested: 2010 to 2020
Year(s) Requested: to

☐ Check this box if you want the earnings information **CERTIFIED** for an additional $34.00 fee.

☐ **Certified Yearly Totals of Earnings $34.00**
(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 Strategic Litigation Partners, LP

Address 21324 Provincial Blvd State TX

City Katy ZIP Code 77450

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

Signature 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 $91.00 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 $34.00 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 $34.00 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: **Social Security Administration** P.O. Box 33011 Baltimore, Maryland 21290-33011	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

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

Non-Certified Itemized Statement of Earnings	**Certified** Itemized Statement of Earnings
$91.00	$125.00

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

Certified yearly totals of earnings cost $34.00. 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 $34.00, $91.00, or $125.00. 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:**

Strategic Litigation Partners, LP

***ADDRESS OF PERSON OR ORGANIZATION:**

21324 Provincial Blvd

Katy, TX 77450

***I want this information released because:** Litigation

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. [X] Verification of Social Security Number
2. [X] Current monthly Social Security benefit amount
3. [X] Current monthly Supplemental Security Income payment amount
4. [X] My benefit or payment amounts from date 2010 to date 2020
5. [X] My Medicare entitlement from date 2010 to date 2020
6. [X] Medical records from my claims folder(s) from date 2010 to date 2020

   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. [X] 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.)

   SSA Form under other records; Assessments; Questionnaires; Application for Claims; DDS Determinations; Award or Denial Letters; SSA Form 821; SSA Form 3368

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**

(March 2019)

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

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

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

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

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

Caution: If the tax return is being mailed to a third party, ensure that you have filled in lines 6 and 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax return to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your return information, you can specify this limitation in your written agreement with the third party.

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

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

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

_____ _____ _____ _____

_____ _____ _____ _____

8 **Fee.** There is a $50 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.**

a	Cost for each return	$ 50.00
b	Number of returns requested on line 7	
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

▶ _____ **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ **Spouse's signature** _____ Date

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

Future Developments

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

General Instructions

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

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

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

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

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

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

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

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	Internal Revenue Service RAIVS Team Stop 37106 Fresno, CA 93888
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999

Chart for all other returns

If you lived in or your business was in:	Mail to:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, 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 your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

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

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

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

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

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.

EXHIBIT 4

AUTHORIZED IN CONNECTION WITH

In Re: Tasigna Products Liability Litigation,
Docket No.: BER-L-5018-21 (N.J. Super. Ct.)

AUTHORIZATION FOR RELEASE OF NEW JERSEY DIVISION OF TAXATION RECORDS

To: _____
Name of Entity

_____
Address

_____
City, State, Zip Code

Re: _____
Name of Tax Payer Date of Birth Social Security No.

You are hereby authorized to release copies of my entire tax file, including but not limited to any and all previously filed income tax returns, whether generated by you or provided to you by another entity, to include all archived records, records in storage, and all items as may be stored in a computer database or in electronic form or in paper form. The Records Requesters have agreed to pay reasonable charges to supply copies of such records. All documents and information should be provided to:

Records Requesters

1. HOLLINGSWORTH LLP, 1350 I Street, N.W., Washington, D.C. 20005-3305, (202) 898-5800, or any member, associate, or designee of the firm, and/or
    a. Strategic Litigation Partners, LP, 21324 Provincial Blvd, Katy, TX 77450 as agent for Hollingsworth, LLP.

This authorization is being given at my request in conjunction with the civil litigation matter listed above. Therefore, this authorization shall expire upon the

final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other final judicial order, including but not limited to the resolution of any and all appeals. Until then, this authorization shall be considered as continuing, and you may rely on it in all respects unless and until you have been advised by me in writing to the contrary. Please note that this authorization also permits you to release any records created or obtained by you after the date of execution of this authorization.

It is expressly understood and intended by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Date:_____

_____

Tax Payer/Representative Signature
[Print name if not Tax Payer]

EXHIBIT 5

AUTHORIZED IN CONNECTION WITH

In Re: Tasigna Products Liability Litigation,
Docket No.: BER-L-5018-21 (N.J. Super. Ct.)

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

To: _____
Name of Entity

_____
Address

_____
City, State, Zip Code

Re: _____
Name of Employee **Date of Birth** **Social Security No.**

You are hereby authorized to release copies of my entire personnel file to the Records Requester listed below. This release authorizes you to furnish copies of all personnel records including but not limited to documents relating to attendance, leave of absences (whether for vacation, sick leave or other reasons), reported injuries, promotions and demotions, performance evaluations, reports of health examinations, job applications, and wages paid and/or earnings given (including W-2 forms), and all other pertinent documents, including any and all medical, psychological, or testing records or memoranda whether generated by you or provided to you by another entity, to include all archived records, records in storage, and all items as may be stored in a computer database or in electronic form or in paper form.

The Records Requesters have agreed to pay reasonable charges to supply copies of such records. Copies of any records obtained will be provided to my legal counsel. You should provide all documents and information:

Records Requesters

1. HOLLINGSWORTH, LLP 1350 I Street, N.W., Washington, D.C. 20005-3305, (202) 898-5800, or any member, associate, or designee of the firm, and/or
    a. Strategic Litigation Partners, LP, 21324 Provincial Blvd, Katy, TX 77450 as agent for Hollingsworth, LLP.

This authorization is being given at my request in conjunction with the civil litigation matter listed above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other final judicial order, including but not limited to the resolution of any and all appeals. Until then, this authorization shall be considered as continuing, and you may rely on it in all respects unless and until you have been advised by me in writing to the contrary. Please note that this authorization also permits you to release any records created or obtained by you after the date of execution of this authorization.

It is expressly understood and intended by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Date:_____

_____

Employee/Representative Signature
[Print name if not Employee]

EXHIBIT 6

INSTRUCTION AND INFORMATION SHEET FOR SF 180, REQUEST PERTAINING TO MILITARY RECORDS

1. General Information. The Standard Form 180, Request Pertaining to Military Records (SF180) is used to request information from military records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available." Include as much of the requested information as you can. To determine where to mail this request see Page 2 of the SF180 for record locations and facility addresses.

Online requests may be submitted to the National Personnel Records Center (NPRC) by a veteran or deceased veteran's next of kin using eVetRecs at http://www.archives.gov/veterans/evetrecs/.

2. Personnel records and Service Treatment Records (STR). Personnel records of military members who were discharged, retired, or died in service **less than 62 years** ago and STR's are in the legal custody of the military service department and are administered in accordance with rules issued by the Department of Defense and the Department of Homeland Security (DHS, Coast Guard). STR's of persons on active duty are generally kept at the local servicing clinic, and usually are available from the Department of Veterans Affairs approximately 40 days after the last day of active duty. (See item 3, Archival Records, if the military member was discharged, retired or died in service over 62 years ago.)

a. Release of information: Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations and the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's legal guardian has access to almost any information contained in that member's own record. An authorization signature, of the service member or the member's legal guardian, is needed in Section III of the SF180. Others requesting information from military personnel records and/or STR's must have the release authorization in Section III of the SF 180 signed by the member or legal guardian. If the appropriate signature cannot be obtained, only limited types of information can be provided. If the former member is deceased, surviving next of kin may, under certain circumstances, be entitled to greater access to a deceased veteran's records than a member of the general public. The next of kin may be any of the following: unremarried surviving spouse, father, mother, son, daughter, sister, or brother. Requesters must provide proof of death, such as a copy of a death certificate, letter from funeral home or obituary.

b. Fees for records: There is no charge for most services provided to service members or next of kin of deceased veterans. A nominal fee is charged for certain types of service. In most instances service fees cannot be determined in advance. If your request involves a service fee, you will be notified as soon as that determination is made.

3. Archival Records. Personnel records of military members who were discharged, retired, or died in service **62 or more years** ago have been transferred to the legal custody of NARA and are referred to as "archival" records.

a. Release of Information: Archival records are open to the public. The Privacy Act of 1974 does not apply to archival records, therefore, written authorization from the veteran or next of kin is not required. However, in order to protect the privacy of the veteran, his/her family, and third parties named in the records, the personal privacy exemption of the Freedom of Information Act (5 U.S.C. 552 (b) (6)) may still apply and preclude the release of some information.

b. Fees for Archival Records: Access to archival records is granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). You will be notified if there is a charge for photocopies of documents contained in the record you are requesting.

4. Where reply may be sent. The reply may be sent to the service member or any other address designated by the service member or other authorized requester.

5. Definitions and abbreviations. DISCHARGED -- the individual has no current military status; SERVICE TREATMENT RECORD (STR) -- The chronology of medical, mental health and dental care received by service members during the course of their military career (does not include records of treatment while hospitalized); TDRL – Temporary Disability Retired List.

6. Service completed before World War I. National Archives Trust Fund (NATF) forms must be used to request these records. Obtain the forms by e-mail from *inquire@nara.gov* or write to the Code 6 address on page 2 of the SF 180.

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e)(3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the facility servicing the service member's record may not have all of the information needed to locate it. The purpose of the information on this form is to assist the facility servicing the records (see the address list) in locating the correct military service record(s) or information to answer your inquiry. This form is then retained as a record of disclosure. The form may also be disclosed to Department of Defense components, the Department of Veterans Affairs, the Department of Homeland Security (DHS, U.S. Coast Guard), or the National Archives and Records Administration when the original custodian of the military health and personnel records transfers all or part of those records to that agency. If the service member was a member of the National Guard, the form may also be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served.

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

Public burden reporting for this collection of information is estimated to be five minutes per request, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (NHP), 8601 Adelphi Road, College Park, MD 20740-6001. DO NOT SEND COMPLETED FORMS TO THIS ADDRESS. SEND COMPLETED FORMS AS INDICATED IN THE ADDRESS LIST ON PAGE 2 OF THE SF 180.

Standard Form 180 (Rev. 09/08) (Page 1)
Prescribed by NARA (36 CFR 1228.168(b))
Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 10/31/2011

REQUEST PERTAINING TO MILITARY RECORDS

* Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/evetrecs/ *

(To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type.)

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

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

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

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU WOULD LIKE TO REQUEST A COPY OF:

☐ **DD Form 214 or equivalent.** This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. NOTE: If more than one period of service was performed, even in the same branch, there may be more than one DD214. **Check the appropriate box below to specify a deleted or undeleted copy.** When was the DD Form(s) 214 issued? YEAR(S):

☐ **UNDELETED:** Ordinarily required to determine eligibility for benefits. Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

☐ **DELETED:** The following items are deleted: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

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

☐ **Medical Records** (Includes Service Treatment Records (outpatient), inpatient and dental records.) If hospitalized, provide facility name and date for each admission:

☐ **Other** (Specify):

2. PURPOSE: (An explanation of the purpose of the request is **strictly voluntary**; however, such information may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.) Check appropriate box:

☐ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Medals/Awards ☐ Genealogy ☐ Correction ☐ Personal

☐ Other, explain:

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER IS: *(Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.)*

☐ Military service member or veteran identified in Section I, above

☐ Next of kin of deceased veteran (Must provide proof of death).

Show relationship: _____

(See item 2a on accompanying instructions.)

☐ Legal guardian (Must submit copy of court appointment.)

☐ Other (specify) _____

2. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

Name

Street Apt.

City State Zip Code

3. AUTHORIZATION SIGNATURE REQUIRED *(See items 2a or 3a on accompanying instructions.)* I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct.

Signature Required - Do not print

Date of this request ( ) Daytime phone

Email address

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

LOCATION OF MILITARY RECORDS

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	ADDRESS CODE	
		Personnel Record	Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired on or after 10/1/2004	1	11
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, retired reserve in nonpay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	13	
COAST GUARD	Discharge , deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired on or after 4/1/1998	14	11
	Active, reserve, or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1905	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired on or after 1/1/1999	4	11
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	14
	Discharged, deceased, or retired after 10/16/1992	14	11
	Reserve; or active duty records of current National Guard members who performed service in the U.S. Army before 7/1/1972	7	
	Active enlisted (including National Guard on active duty in the U.S. Army) or TDRL enlisted	9	
	Active officers (including National Guard on active duty in the U.S. Army) or TDRL officers	8	
	Current National Guard enlisted and officer not on active duty in Army (including records of Army active duty performed after 6/30/1972)	13	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired on or after 1/1/1995	10	11
	Active, reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1	Air Force Personnel Center HQ AFPC/DPSSRP 550 C Street West, Suite 19 Randolph AFB, TX 78150-4721	6	National Archives & Records Administration Old Military and Civil Records (NWCTB-Military) Textual Services Division 700 Pennsylvania Ave., N.W. Washington, DC 20408-0001	11	Department of Veterans Affairs Records Management Center P.O. Box 5020 St. Louis, MO 63115-5020
2	Air Reserve Personnel Center /DSMR HQ ARPC/DPSSA/B 6760 E. Irvington Place, Suite 4600 Denver, CO 80280-4600	7	U.S. Army Human Resources Command ATTN: AHRC-PAV-V 1 Reserve Way St. Louis, MO 63132-5200	12	Division of Commissioned Corps Officer Support ATTN: Records Officer 1101 Wooton Parkway, Plaza Level, Suite 100 Rockville, MD 20852
3	Commander, CGPC-adm-3 USCG Personnel Command 4200 Wilson Blvd., Suite 1100 Arlington, VA 22203-1804	8	U.S. Army Human Resources Command ATTN: AHRC-MSR 200 Stovall Street Alexandria, VA 22332-0444	13	The Adjutant General (of the appropriate state, DC, or Puerto Rico)
4	Headquarters U.S. Marine Corps Personnel Management Support Branch (MMSB-10) 2008 Elliot Road Quantico, VA 22134-5030	9	Commander USAEREC ATTN: PCRE-F 8899 E. 56th St. Indianapolis, IN 46249-5301	14	National Personnel Records Center (Military Personnel Records) 9700 Page Ave. St. Louis, MO 63132-5100 *http://www.archives.gov/veterans/evetrecs/*
5	Marine Corps Mobilization Command 15303 Andrews Road Kansas City, MO 64147-1207	10	Navy Personnel Command (PERS-312E) 5720 Integrity Drive Millington, TN 38055-3120		