

In Re: ACCUTANE® LITIGATION

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY

Case Code No. _____

PLAINTIFF'S FACT SHEET

Plaintiff: _____
(name)

This Fact Sheet and the attached List of Medical Providers and Other Sources of Information must be completed by each plaintiff who used ACCUTANE® or their personal representative. In filling out this form, please use the following definitions:

(1) **"health care provider"** means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric, mental, emotional or psychological care or advice, and any pharmacy, counselor, dentist, X-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, therapist, nurse, herbalist, nutritionist, dietician or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you or your decedent;

(2) **"document"** means any writing or record or any type, however produced and whatever the medium on which it was produced or reproduced, and includes, without limitation, the original and any non-identical copy (whether different from the original because of handwritten notes or underlying on the copy or otherwise) and all drafts of papers, letters, telegrams, telexes, notes, notations, memoranda of conversations or meeting, calendars, diaries, minutes of meetings, interoffice communications, electronic mail, message slips, notebooks, agreements, reports, articles, books, tables, charts, schedules, memoranda, medical records, X-rays, advertisements, pictures, photographs, films, accounting books or records, billings, credit card records, electrical or magnetic recordings or tapes, or any other writings, recordings, or pictures of any kind of description.

I. CASE INFORMATION

A. Name of person completing this form: _____

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

1. Case Caption: _____

2. Case No.: _____

3. Please state the name, address, and telephone number of the principal attorney representing you:

Name

Firm

City, State and Zip Code

Telephone number

4. When did you first contemplate obtaining an attorney regarding any injury(ies) which you now allege is associated with Accutane®?

5. When did you first contact an attorney regarding any injury(ies) which you now allege is associated with Accutane®? (This question asks for the first contact with any attorney including but not limited to your present attorney.)

C. If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following: If not, skip this question.

1. _____
Your Name and Social Security Number

2. _____
Maiden Or Other Names Used or By Which You Have Been Known

3. _____
Street Address

4. _____
City, State and Zip Code

You may attach as many sheets of paper as necessary to fully answer these questions.

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5. If you are in a representative capacity, state which individual or estate you are representing, and in what capacity you are representing the individual or estate: _____
6. If you were appointed as a representative by a court, state the:

Court	Date of Appointment
7. Your relationship to deceased or represented person or person claimed to be injured: _____
8. If you represent a decedent's estate based on a decedent's death, state the date of death of the decedent and the address of the place where the decedent died: _____

If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who used ACCUTANE®, unless the question instructs you otherwise. Those questions using the term "You" refer to the person who used the ACCUTANE®, unless you are instructed otherwise. 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. [This section will be tailored to the allegations in the complaint.]

D. Claim Information

1. What bodily injury(ies)/condition(s) do you claim resulted from your use of ACCUTANE®? If you state severe organ damage, please state specifically which organ and the alleged injury(ies). Be very specific about each and every injury claimed

2. When do you claim this injury(ies)/condition(s) occurred?

3. Who diagnosed the condition(s)?

4. Physician/healthcare provider(s) who related condition(s)/diagnosis(es) to Accutane®.

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5. Date of diagnosis for each condition(s) alleged to have been caused by Accutane®.

6. Did you ever suffer this injury(ies) prior to the date set forth in answer to the prior question? If yes, when and who diagnosed the condition(s) at that time?

7. Do you claim that that your use of ACCUTANE® worsened a condition(s) that you already had or had in the past?

Yes _____ No _____ Don't Know _____

If yes, set forth the injury(ies) or condition(s); whether or not you had already recovered from that injury(ies) or condition(s) before you took ACCUTANE®; and the date of recovery, if any.

8. Is there a family history of the same or similar condition(s) you claim resulted from your use of Accutane®? (For example, if you claim Crohn's Disease, please list all gastrointestinal condition(s).)

Yes _____ No _____

If so, who (father, mother, brother, grandmother, etc.).

II. PERSONAL INFORMATION OF THE PERSON WHO USED ACCUTANE®

A. Last Name: _____
First Name: _____
Middle Name or Initial: _____

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

C. Social Security Number: _____

D. Present Street Address: _____

City State Zip Code

E. Identify each other address at which you have resided during the last ten (10) years, and list when you started and stopped living at each one:

_____ From _____ To _____
_____ From _____ To _____
_____ From _____ To _____
_____ From _____ To _____
_____ From _____ To _____
_____ From _____ To _____
_____ From _____ To _____

F. Identify each grammar/grade school, high school, college, university or other educational institution you have attended, the dates of attendance, courses of study pursued, and diplomas or degrees awarded:

G. Employment Information.

1. Current employer (if not currently employed, last employer):

Name

Address

Dates of Employment

Occupation/Job Duties

2. List the following for each employer you have had in the last ten (10) years:

Name

Address

Dates of Employment

Occupation/Job Duties

Name

Address

Dates of Employment

Occupation/Job Duties

Name

Address

Dates of Employment

Occupation/Job Duties

You may attach as many sheets of paper as necessary to fully answer these questions.

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H. Driver's License Number and State Issuing License: [If you have had drivers licenses in more than one state, list response for each state.]

I. Date and Place of Birth: _____

J. Sex: Male _____ Female _____

K. Military Service Information

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

Yes _____ No _____

If yes, please state:

1. What branch and the dates of service:

2. Were you discharged for any reason relating to your physical, psychiatric or emotional condition(s)?

Yes _____ No _____

If yes, state what that condition(s) was.

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

Yes _____ No _____

If yes, state what that condition(s) was.

3. Have you ever served in the military overseas?

Yes _____ No _____

If yes, state location and dates.

L. Insurance/Claim Information

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

Yes _____ No _____

If yes, please state:

1. Year claim was filed: _____

2. Court/State where claim was filed: _____

3. Claim/ docket number, if applicable: _____

4. Nature of disability: _____

You may attach as many sheets of paper as necessary to fully answer these questions.

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5. Period of disability: _____
6. Benefits received, if any: _____

[Attach additional sheets if necessary to provide all of this information for more than one claim]

2. Have you ever filed a social security disability claim (SSI or SSD)?
Yes _____ No _____

If yes, please state

1. Year claim was filed: _____
2. Where claim was filed: _____
3. Nature of disability: _____
4. Period of disability: _____
5. Benefits received, if any: _____

[Attach additional sheets if necessary to provide all of this information for more than one claim]

3. Have you ever been denied life insurance or medical insurance for reasons relating to your medical or physical condition(s)?
Yes _____ No _____

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

4. ***(Answer this question if you are claiming damages for mental or emotional distress.)*** Have you ever been denied life insurance or medical insurance for reasons relating to your mental or emotional condition(s)?

Yes _____ No _____

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

5. Has any insurance or other company provided medical coverage to you (either directly or through a group including any employer of yours) or paid medical bills on your behalf at any time, beginning ten (10) years before your alleged injury(ies) through the present?

Yes _____ No _____

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If yes, then as to each company, separately state:

Name of the company: _____

Address of the company: _____

The account/policy number or designation: _____

Dates of coverage: _____

When claim was made: _____

6. Have you ever been out of work for more than thirty (30) days for reasons related to your health? If yes, set forth when and the reason.

Yes _____ No _____

When: _____

Reason: _____

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

Yes _____ No _____

If so, state the court in which such action was filed, the caption, case name and/or names of adverse parties, and the civil action or docket number assigned to each claim, action or suit, and a brief description for the claims asserted.

- M. Have you ever been convicted of a crime? If yes, set forth where, when and the crime.

Yes _____ No _____

FAMILY INFORMATION

N. List for each marriage the name of your spouse; spouse's date of birth (for your current spouse only); spouse's occupation; date of marriage; date the marriage ended, if applicable; and how the marriage ended (e.g., divorce, annulment, death):

O. List the names of your parents and whether they are still married.

P. List the names of your paternal and maternal grandparents and whether they are still living. If deceased, list date and cause of death.

Q. To the best of your current knowledge or present recollection, has any parent, grandparent, child, or sibling ever been diagnosed with a problem or condition(s) relating to the same organ or organ system identified in your answer to Section I(D)?

Yes _____ No _____ Don't Know _____

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

1. Name: _____
Current Age (or Age at Death): _____
Type of Problem: _____
If Applicable, Cause of Death: _____
2. Name: _____
Current Age (or Age at Death): _____
Type of Problem: _____
If Applicable, Cause of Death: _____
3. Name: _____
Current Age (or Age at Death): _____
Type of Problem: _____
If Applicable, Cause of Death: _____

R. If applicable, for each of your children, list his/her name, age, occupation and address:

S. If you are bringing a survivor cause of action, state whether you have been appointed as the decedent's personal representative authorized to prosecute the decedent's claims, and when and by whom you were so appointed.

III. CURRENT MEDICAL CONDITION(S)

A. Do you currently suffer from any physical injuries, illnesses or disabilities other than those you alleged are the result of your use of ACCUTANE®?

Yes _____ No _____

B. If the answer is yes, please state the following for each injury(ies), illness or disability:

1. Identify the injury(ies), illness, or disability, their symptoms and date of onset. Injury(ies), illness, or disability, and their symptoms:

Date of onset: _____

2. By whom first diagnosed:

Name

Address (if not otherwise provided)

Date of diagnosis

IV. MEDICAL BACKGROUND

- A. Height: _____
- B. Current Weight: _____
Weight at the time of the injury, illness, or disability described in section I(D):

C. Prescription Medicines

- 1. To the best of your recollection, list each prescription medicine, including but not limited to oral contraceptives (as applicable), you have taken regularly in the last ten (10) years, identifying the medication and the condition(s) for which it was prescribed.

- 2. To the best of your recollection, list each prescription medicine you have taken intermittently in the last ten (10) years, identifying the medication and the condition(s) for which it was prescribed.

- 3. To the best of your recollection, state whether you used any of the following from ten (10) years prior to the date of the injury(ies) you allege in section I(D) through the present, circle all medications you have used, when you took the medication and how frequently, and if a doctor prescribed or suggested the medication, identify the doctor.

a. NSAIDS (such as):

<u>Substance</u>	<u>When taken and How Frequently</u>	<u>Prescribing Doctor (if any)</u>
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Advil	_____	_____
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Ibuprofen	_____	_____
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<u>Substance</u>	<u>When taken and How Frequently</u>	<u>Prescribing Doctor (if any)</u>
Aleve	_____	_____
Naprosyn	_____	_____
Motrin	_____	_____
Orudis	_____	_____
Feldene	_____	_____
Indocin	_____	_____
Toradol	_____	_____
Daypro	_____	_____
Celebrex	_____	_____

b. Herbal Remedies or Supplements:

<u>Substance</u>	<u>When taken and How Frequently</u>	<u>Prescribing Doctor (if any)</u>
Kava	_____	_____
Ginseng	_____	_____
Ginko Bilboa	_____	_____
St. John's Wort	_____	_____
Sal Palmetto	_____	_____

D. Smoking/Tobacco Use History (circle whichever is applicable):

- Never smoked cigarettes/cigars/pipe tobacco or used chewing tobacco/snuff.
- Past smoker of cigarettes/cigars/pipe tobacco or used chewing tobacco/snuff.
Date on which smoking/tobacco use ceased: _____
Amount smoked or used: _____ per day for _____ years.
- Current smoker of cigarettes/cigars/pipe tobacco or user of chewing tobacco/snuff.
Amount smoked or used: _____ per day for _____ years.

E. Drinking History:

- Do you now drink or have you in the past drunk alcohol (beer, wine, whiskey, etc.)?

You may attach as many sheets of paper as necessary to fully answer these questions.

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Yes _____ No _____

If no, go to Section F below. If yes, check the following box which represents your greatest alcohol consumption over an extended (6 months or greater) period within the last 10 years:

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

Check the following box which represents your weekly alcohol consumption for the month prior to the first symptom (gastrointestinal or other symptoms related to your injury) you experienced:

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

F. Caffeine and Sugar Intake History:

1. Do you now or have you in the past consumed caffeinated beverages (coffee, tea, sodas, etc.)?

Yes _____ No _____

If yes, check the following box which represents your greatest caffeine consumption over an extended (6 months or greater) period within the last 10 years:

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

Check the following box which represents your weekly caffeine consumption for the month prior to the time that you sustained the injuries alleged in the complaint:

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

2. Do you now or have you in the past consumed sugared beverages or desserts?

Yes _____ No _____

You may attach as many sheets of paper as necessary to fully answer these questions.

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If yes, check the following box which represents your greatest sugar consumption over an extended (6 months or greater) period within the last 10 years:

- _____ 1-5 items per week
- _____ 6-10 items per week
- _____ 11-14 items per week
- _____ 15 or more items per week
- _____ Other (describe) _____

Check the following box which represents your weekly sugar consumption for the month prior to the time that you sustained the injuries alleged in the complaint:

- _____ 1-5 items per week
- _____ 6-10 items per week
- _____ 11-14 items per week
- _____ 15 or more items per week
- _____ Other (describe) _____

G. ***If you are claiming damages for mental or emotional distress as a consequence of ACCUTANE®, state whether you have experienced or been treated for any psychological, psychiatric or emotional problem prior to the use of ACCUTANE®, including but not limited to panic attacks, anxiety, post traumatic stress disorder, depression, thoughts of hurting yourself or other people, schizophrenia, bipolar disorder, personality disorders (e.g., obsessive compulsive, paranoid, borderline, histrionic, other), generalized anxiety disorder, social phobia/anxiety disorder, mania, poor sleep, poor concentration, suicidal thoughts/attempts, and drug abuse.***

Yes _____ No _____

If yes, state:

1. Name and address of each health care provider who treated you:

Name

Address (if not otherwise provided)

2. Condition(s) for which treated: _____

3. When treated: _____

4. Medications prescribed for such condition(s): _____

H. To the best of your knowledge or understanding, have you ever experienced, or been told by a doctor or other healthcare professional, that you have, may have or had any of the following at any time in your life.

<u>Symptom/Condition</u>	<u>Yes</u>	<u>No</u>	<u>I don't know</u>
Abdominal pain			
Allergic reaction to medication			
Anemia			
Arthritis			
Back pain and/or neck injury			
Bleeding/clotting disorders (hemophilia, Von Willebrand's disease, scurvy, other)			
Blood Disorders			
Blood in stool or dark/black stools			
Blurry vision lasting more than a few days			
Bone fracture			
Bone problems/pain/disease			
Calcification of Tendons and Ligaments			
Cancer (lung, colon, liver, breast, testicular, other)			
Chest pain/angina (at rest or with exertion)			
Chronic Fatigue Syndrome			
Chronic obstructive pulmonary disease/COPD			
Colitis			
Congenital heart disease			
Congestive heart failure			
Corneal Opacity			
Corneal Ulcer			
Coronary artery disease			
Coronary heart disease			
Crohn's Disease			
Deep vein thrombosis/DVT/blood clot in lower legs			
Degenerative disc			
Dermatomyositis			

You may attach as many sheets of paper as necessary to fully answer these questions.

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<u>Symptom/Condition</u>	<u>Yes</u>	<u>No</u>	<u>I don't know</u>
Diabetes			
Dizziness lasting more than a few days			
Drowsiness lasting more than a few days			
Elevated cholesterol			
Elevated liver enzymes			
Elevated triglycerides			
Esophagus problems (strictures, achalasia, esophagitis, Barrett's esophagus, difficulty swallowing, other)			
Eye hemorrhages			
Fibromyalgia			
Gall bladder problems (gall stones, other)			
Gastrointestinal problems			
Gout			
Headaches lasting more than a few days			
Heart attack/MI/myocardial infarction			
Heart problems (including but not limited to heart attack, heart murmurs, heart valve problems, heart palpitations, heart rate/rhythm problems, congestive heart failure, cor pulmonale, etc.)			
Heartburn/ reflux/ esophageal reflux disease/ GERD			
Hepatotoxicity			
Hernia (strangulated or incarcerated)			
High blood pressure/hypertension			
High triglycerides			
Hodgkin's disease/ non-Hodgkin's lymphoma			
Hypoxia (low oxygen saturation)			
Ileitis			
Inflammatory bowel disease			
Insomnia lasting more than a few days			
Intestinal hemorrhage			
Intestinal obstruction (not including constipation)			

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<u>Symptom/Condition</u>	<u>Yes</u>	<u>No</u>	<u>I don't know</u>
Irregular heart rhythm			
Irritable bowel syndrome			
Itching (persistent lasting more than one week)			
Joint pain lasting more than a few days			
Keratitis			
Kidney problems (disease, infection, stones, protein in urine, etc.)			
Leukemia			
Liver disease (hepatitis B/C, cirrhosis, cysts, abnormal enzymes, etc.)			
Lupus			
Lymphadenopathy			
Measles			
Musculoskeletal problems			
Nausea (repetitive bouts lasting more than a few days)			
Night vision loss			
Obesity			
Optic neuritis			
Oral herpes (canker sores)			
Osteoarthritis			
Pancreatitis			
Paresthesias			
Peptic ulcer disease			
Peripheral vascular disease			
Premature epiphyseal closure			
Pseudotumor cerebri psychosis			
Pulmonary embolism/blood clot in the lung			
Pyoderma faciale			
Rectal bleeding			
Regional ileitis			

You may attach as many sheets of paper as necessary to fully answer these questions.

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<u>Symptom/Condition</u>	<u>Yes</u>	<u>No</u>	<u>I don't know</u>
Rheumatic fever (as to you only, if applicable)			
Rhabdomyolysis			
Rheumatoid arthritis			
Scheuermann's Kyphosis			
Seizure disorder			
Shortness of breath not associated with vigorous exercise			
Silent MI			
Skeletal hyperostosis			
Sleep apnea			
Stomach problems (ulcers, perforations, bleeding)			
Stroke			
Swelling/edema/fluid in legs ankles (other than in pregnancy)			
Syncope			
Tendonitis			
Thyroid disorder and/or goiter			
Transient chest pain			
Transient ischemic attack/TIA			
Tuberculosis			
Ulcerative colitis			
Urogenital condition(s)			
Vascular problems			
Vascular thrombotic disease			
Vasculitis			
Vision problems lasting more than a few days			
Vomiting lasting more than a few days			

- I. If you responded "yes" to any of the above, please identify/state the condition(s), the date of onset, any medication prescribed to treat the condition(s), and the name of the physician or other person who made the

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diagnosis or informed you of the condition(s) and their address if not provided in the accompanying list.

1. Condition(s): _____
Onset date and medication: _____
Name and address of physician or other person: _____

2. Condition(s): _____
Onset date and medication: _____
Name and address of physician or other person: _____

3. Condition(s): _____
Onset date and medication: _____
Name and address of physician or other person: _____

4. Condition(s): _____
Onset date and medication: _____
Name and address of physician or other person: _____

5. Condition(s): _____
Onset date and medication: _____
Name and address of physician or other person: _____

J. Please indicate whether you have ever received any of the following treatments or diagnostic procedures:

1. Surgeries, including but not limited to the following, and specify for what condition(s) the surgery was performed: open heart/bypass surgery, vascular surgery, intestinal surgery, etc..

Surgery and condition(s) for which it was performed: _____

When: _____

Treating physician: _____

Hospital: _____

2. Treatments/interventions for heart attack, angina (chest pain), or lung ailments, including but not limited to the following: cardiac catheterization, angioplasty (balloon), stenting, electroconversion.

Treatment/intervention: _____

When: _____

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Treating physician: _____

Hospital: _____

3. Have you had any of the following tests performed: chest X-ray, CT scan, MRI, any other type of x-ray, colonoscopy, upper or lower GI, EKG, echocardiogram, bleeding scan, endoscopy, lung bronchoscopy, carotid duplex/ultrasound, or CT scan of the head. If so, answer the following:

Diagnostic test: _____

When: _____

Treating physician: _____

Hospital: _____

Reason: _____

- K. Have you ever participated in any clinical trials or studies relating to any drugs or treatments for any medical condition(s)s?

Yes _____ No _____

If "Yes", please identify:

Name of the trial or study: _____

Sponsor of trial or study: _____

Drug or treatment studied: _____

Purpose of the drug or treatment studied: _____

Name and address of the investigator in charge of your care and treatment in the trial or study: _____

The dates you participated in the trial or study: _____

- L. To the best of your knowledge, have your parents, grandparents, children or siblings ever experienced or been diagnosed with, or been told by a doctor or other healthcare professional, that they have, may have or had any of the following (circle all that apply), set forth the name of the individual and their relationship to you next to each condition(s) circled?

<u>Symptom/Condition</u>	<u>Name of Individual</u>	<u>Relationship</u>
Gastrointestinal pain (repetitive bouts)		
Blood in stool or dark/black stools		
Bone pain/problems/disease		
Cancer (lung, colon, liver, breast,		

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testicular, other)			
Depression/Psychiatric disorders			
Diabetes			
Elevated cholesterol/lipids			
Heart problems of any type including arthrosclerotic disease			
Any kind of bowel disease/disorder (including Crohn's, ulcerative colitis or irritable bowel syndrome)			
Kidney disease/stones			
Liver disease (hepatitis B/C, cirrhosis, cysts, other)			
Lupus			
Musculoskeletal disease/disorder			
Pancreatitis			
Stroke			
Thyroid disease/disorder (goiter, etc.)			
Vision disorder			

You may attach as many sheets of paper as necessary to fully answer these questions.

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V. **ACCUTANE® PRESCRIPTION INFORMATION**

A. Who prescribed ACCUTANE® for you?

B. On which dates did you begin to take, and stop taking, ACCUTANE®? If you took Accutane® more than once, list each date and the start and stop date.

C. For what condition(s) were you prescribed ACCUTANE®?

D. Did you renew your prescription for ACCUTANE®? If yes, how many times?

E. Where were you living when you took ACCUTANE®?

F. **Pharmacy Information.** If you received a prescription for ACCUTANE®, state for each prescription the name and address of the pharmacy where it was filled, and the number of times it was filled:

G. 1. Have you had discussions with any doctor about whether your claimed injury(ies) is related to the use of ACCUTANE®?

Yes _____ No _____

You may attach as many sheets of paper as necessary to fully answer these questions.

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2. Identify the doctor or doctors with whom you had such discussions.

Name

Address (if not otherwise provided)

[If discussed with more than one doctor, please copy and complete Part 2 for each.]

H. State whether you requested that any doctor or clinic provide you with ACCUTANE® or a prescription for ACCUTANE®.

Yes _____ No _____

I. Were you given any written instructions or warnings regarding the use of ACCUTANE®?

Yes _____ No _____

If yes, state:

1) When the written instructions or warnings were given:

2) A description of the written warnings or instructions (e.g., package insert, patient product information; pharmacy handout, etc.):

3) Identify each person or entity from whom you received the warnings or instructions: _____

Approximate date you received the written instructions or warnings: _____

Summary of instructions/warnings received: _____

J. What other medications (including aspirin), if any, were you taking at the same time you were taking ACCUTANE®?

K. 1. To the best of your recollection what other medications (other than those set forth elsewhere in the Fact Sheet) including, but not limited to, oral

You may attach as many sheets of paper as necessary to fully answer these questions.

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contraceptives (as applicable) and over-the-counter medication, had you taken five (5) years before you took Accutane®, and when did you take them? Please also state when you took the medication, how frequently and if prescribed by a physician, the name of the physician.

2. Do you believe you ever experienced gastrointestinal problems or other adverse side effects from any or all of these other medications? If yes, list the type of adverse side effect, the medication you were taking and the date(s) on which you experienced the adverse side effect.

3. Did you believe you experienced any of the adverse side effects listed in your answer to the preceding question while taking ACCUTANE®? If so, set forth which adverse side effect you experienced, when, what treatment you received for the adverse side effect, and who prescribed that treatment.

- L. On what date, and in what city and state, did you first experience any symptoms you believe are related to the injury(ies) alleged in your complaint and what were those symptoms?

- M. Were there any witnesses to the symptoms identified above? If so, state their names, addresses, phone numbers and relationships to you.

- N. When did you first contact a doctor or healthcare professional concerning this injury(ies)? Whom did you contact?

You may attach as many sheets of paper as necessary to fully answer these questions.

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- O. If you were taken to a doctor or health care facility for the injury(ies) alleged in your complaint, state the name and address of the persons, police department, fire department, emergency medical workers, or ambulance company that took you to the doctor or health care facility.
-

P. **Wage Loss Claims.** *Answer these questions if you claim or expect to claim that you lost earnings or impairment of earning capacity as a result of any condition(s) that you believe was caused by your use of ACCUTANE®: [If you are not claiming lost wages, skip this section.]*

1. State the total amount of time you have lost from work as a result of any condition(s) that you claim or believe was caused by your use of ACCUTANE® and the amount of income that you lost.
-

2. State your total earned income (including salary, bonus, and benefits) for each of the last 10 years.

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

- Q. Have you paid or incurred any medical expenses that are related to any condition(s) that you claim or believe was caused by your use of ACCUTANE® and for which you seek recovery in the action you have filed?

Yes _____ No _____

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

- R. Has your insurer, or any other entity or person, paid or incurred any medical expenses that are related to any condition(s) that you claim or believe was caused by your use of ACCUTANE® and for which you seek recovery in the action you have filed?

Yes _____ No _____

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

- S. Emotional Distress Claims. *If you are claiming damages for mental or emotional distress*, describe the kind of injury(ies) you allege and when you allegedly suffered it, and list all individuals from whom you received treatment for such injury(ies) and the dates on which treatment was received.

- T. Please identify all person who you believe possess information relevant to your claims in this matter and for each, state his or her name, address, telephone number and a description of the information you believe he or she possesses.

VI. DOCUMENTS AND THINGS

Attach copies of the following non-privileged documents and things to this declaration, to the extent that such materials are currently in your possession, custody, or control, in the possession, custody, or control of your parents, guardians or spouse, or in the possession, custody, or control of your lawyers.

- A. A copy of all prescriptions for ACCUTANE®, any unused ACCUTANE® you received as a result of such prescriptions, receipts, physician or office records, drug containers, packaging and other records that show the period during which you have taken ACCUTANE®, the dosage of ACCUTANE® and the frequency with which you took ACCUTANE®.
- B. All documents that refer or relate to ACCUTANE® obtained from the Food and Drug Administration or other government agencies.
- C. 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.
- D. Copies of all documents from physicians, hospitals, clinics, or any type of health care provider relating to your medical or mental health history. This would include, but not be limited to hospital records, diagnostic test or test results, lab work, rehab records, doctor's office charts, etc.
- E. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, consent forms, pharmacy

You may attach as many sheets of paper as necessary to fully answer these questions.

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handouts or other materials distributed or provided to you when your prescriptions for ACCUTANE® were filled.

- F. Copies of all advertisements or promotions for ACCUTANE® received or reviewed before filing this action.
- G. Executed authorizations.
- H. If you claim you have suffered loss of earnings or earning capacity, all documents that evidence your income/earnings for each of the last ten (10) years.
- I. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider and statements and explanations of benefits from your health care insurer or plan.
- J. Copies of letters testamentary, letters of administration, powers of attorney, guardianship or guardian *ad litem* orders or other documents relating to your status as plaintiff if you are suing on behalf of another individual.
- K. Decedent's death certificate (if applicable).
- L. Report of autopsy, medical examiner, coroner, toxicology, or toher police or investigative reports (if applicable);
- M. Copies of all documents concerning your education including, but not limited to, records of and from all schools attended including but not limited to report cards, progress reports, attendance records, disciplinary reports, transcripts, guidance or counseling records and any class yearbooks.
- N. All documents authored by you which document, record or reflect your physical or mental condition or state of mind before, during and after ACCUTANE® use, including but not limited to diaries or journals, suicide notes, and written or electronic communications.

You may attach as many sheets of paper as necessary to fully answer these questions.

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CERTIFICATION

I certify under penalty of perjury that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, that I have supplied all the documents requested in part VIII of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Print Name

Signature

Date

Print Name
(Loss of Consortium Plaintiff)

Signature

Date

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

EACH PLAINTIFF IS REQUIRED TO FULLY AND ACCURATELY TO THE BEST OF THEIR RECOLLECTION COMPLETE THIS FORM LISTING MEDICAL CARE PROVIDERS AND OTHER SOURCES OF INFORMATION AS REQUESTED.

List the name and address of each of the following:

A. Your current family and/or primary care physician:

Name

Street Address

City, State, Zip Code

B. To the best of your ability, identify each of your primary care physicians for the last ten (10) years. [See definitions as set forth on page 1.]

1.

<hr/> <p>Name</p>	<hr/> <p>Approximate dates</p>
<hr/> <p>Last known address</p>	
<hr/> <p>City, State, Zip Code</p>	

2.

<hr/> <p>Name</p>	<hr/> <p>Approximate dates</p>
<hr/> <p>Last known address</p>	
<hr/> <p>City, State, Zip Code</p>	

3.

<hr/> <p>Name</p>	<hr/> <p>Approximate dates</p>
<hr/> <p>Last known address</p>	
<hr/> <p>City, State, Zip Code</p>	

You may attach as many sheets of paper as necessary to fully answer these questions.

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

5. _____
Name
_____ Approximate dates
Last known address
_____ City, State, Zip Code

C. Each hospital, clinic, or healthcare facility where you have received inpatient treatment during the last ten (10) years.

1. _____
Name
_____ Street Address
_____ City, State, Zip Code
_____ Dates of Admission
_____ Reason for Admission

2. _____
Name
_____ Street Address
_____ City, State, Zip Code
_____ Dates of Admission
_____ Reason for Admission

You may attach as many sheets of paper as necessary to fully answer these questions.

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3. _____
Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission

4. _____
Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission

5. _____
Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission

D. Each hospital, clinic, or healthcare facility where you have received outpatient treatment (including treatment in an emergency room) during the last ten (10) years.

1. _____
Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission

You may attach as many sheets of paper as necessary to fully answer these questions.

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2. _____
Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission
3. _____
Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission
4. _____
Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission
5. _____
Name

Street Address

City, State, Zip Code

Dates of Admission

Reason for Admission

You may attach as many sheets of paper as necessary to fully answer these questions.

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E. Each physician or healthcare provider from whom you have received treatment in the last ten (10) years.

1. _____
Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

2. _____
Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

3. _____
Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

4. _____
Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

You may attach as many sheets of paper as necessary to fully answer these questions.

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5. _____
Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment
6. _____
Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment
7. _____
Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment
8. _____
Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

You may attach as many sheets of paper as necessary to fully answer these questions.

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9. _____
Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

10. _____
Name

Specialty

Street Address

City, State, Zip Code

Dates of Treatment

F. Each pharmacy where you filled or obtained prescription medication in the last ten (10) years.

1. _____
Name

Street Address

City, State, Zip Code

2. _____
Name

Street Address

City, State, Zip Code

G. If you have submitted a claim for social security disability benefits in the last ten (10) years, state the name and address of the office which is most likely to have records concerning your claim. Name Street Address

Name

You may attach as many sheets of paper as necessary to fully answer these questions.

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Street Address

City, State, Zip Code

- H. If you have submitted a claim for worker's compensation, state the name and address of the entity which is most likely to have records concerning your claim.

Name

Street Address

City, State, Zip Code

You may attach as many sheets of paper as necessary to fully answer these questions.

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SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY

In re: ACCUTANE® LITIGATION

Case No. 619

**AUTHORIZATION FOR RELEASE OF
MEDICAL RECORDS PURSUANT TO
45 C.F.R. § 164.508 (HIPAA)**

Name: _____

Date of Birth: _____

Social Security Number: _____

I hereby authorize _____ to release all existing medical records and information regarding the above-named person's medical care, treatment, physical condition(s), and/or medical expenses revealed by observation or treatment past, present and future to the law firm of **GIBBONS, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE, One Riverfront Plaza, Newark, NJ 07102-5497 and/or its designated agent.** These records shall be used solely in connection with the currently pending litigation involving the person named above. This authorization shall cease to be effective as of the date on which that litigation concludes.

I understand that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This authorization also may include x-ray reports, CT scan reports, MRI scans, EEGs, EKGs, sonograms, arteriograms, fetal monitor strips, discharge summaries, photographs, surgery consent forms, informed consent forms regarding family planning, admission and discharge records, operation records, doctor and nurses notes (excluding psychotherapy notes maintained separately from the individual's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress), prescriptions, medical bills, invoices, histories, diagnoses, narratives, and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc.). This listing is not meant to be exclusive.

You may attach as many sheets of paper as necessary to fully answer these questions.

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I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition(s) of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition(s) the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Gibbons, Del Deo, Dolan, Griffinger & Vecchione.

Dated this _____ day of _____, 200__

[PLAINTIFF OR REPRESENTATIVE]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY

In re: ACCUTANE® LITIGATION

Case No. 619

**AUTHORIZATION FOR RELEASE OF
PSYCHOLOGICAL/PSYCHIATRIC
RECORDS PURSUANT TO
45 C.F.R. § 164.508 (HIPAA)**

Name: _____

Date of Birth: _____

Social Security Number: _____

I hereby authorize _____ to release all existing records and information regarding the above-named person's psychological or psychiatric care, treatment, condition(s), and/or expenses revealed by observation or treatment past, present and future to the law firm of **GIBBONS, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE, One Riverfront Plaza, Newark, NJ 07102-5497 and/or its designated agent.** These records shall be used solely in connection with the currently pending litigation involving the person named above. This authorization shall cease to be effective as of the date on which that litigation concludes.

I understand that this authorization includes information regarding the diagnosis and treatment of psychiatric and psychological disorders, and that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This authorization also may include x-ray reports, CT scan reports, MRI scans, EEGs, EKGs, sonograms, arteriograms, fetal monitor strips, discharge summaries, photographs, surgery consent forms, informed consent forms regarding family planning, admission and discharge records, operation records, doctor and nurses notes (excluding psychotherapy notes maintained separately from the individual's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress), prescriptions, medical bills, invoices, histories, diagnoses, psychiatric treatment and counseling records, psychological treatment and counseling records, narratives, and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as

You may attach as many sheets of paper as necessary to fully answer these questions.

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evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc.). This listing is not meant to be exclusive.

I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition(s) of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition(s) the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Gibbons, Del Deo, Dolan, Griffinger & Vecchione.

Dated this _____ day of _____, 200_

[PLAINTIFF OR REPRESENTATIVE]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:

You may attach as many sheets of paper as necessary to fully answer these questions.

#96075 v5
036835-50206

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY

In re: ACCUTANE® LITIGATION

Case No. 619

**AUTHORIZATION FOR RELEASE OF
PSYCHOTHERAPY NOTES PURSUANT
TO 45 C.F.R. § 164.508 (HIPAA)**

Name: _____

Date of Birth: _____

Social Security Number: _____

I hereby authorize _____ to release all existing psychotherapy notes regarding the above-named person's medical care, treatment, physical/mental condition(s), and/or medical expenses revealed by observation or treatment past, present and future to the law firm of **GIBBONS, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE, One Riverfront Plaza, Newark, NJ 07102-5497 and/or its designated agent.** These records shall be used solely in connection with the currently pending litigation involving the person named above. This authorization shall cease to be effective as of the date on which that litigation concludes.

I understand that this authorization includes all psychotherapy notes maintained separately from the above-named person's medical record that document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress.

I understand that the health information being disclosed by these psychotherapy notes may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition(s) of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition(s) the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient to its clients, agents, employees, consultants, experts, the court, and others deemed necessary by the recipient to assist in this litigation.

You may attach as many sheets of paper as necessary to fully answer these questions.

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Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of Gibbons, Del Deo, Dolan, Griffinger & Vecchione.

Dated this ____ day of _____, 200_

[PLAINTIFF OR REPRESENTATIVE]

If a representative, please describe your relationship to the plaintiff and your authority to act on his/her behalf:

PABOS2:CHENNES:616832_1
14690-91141

PLAINTIFF'S
CONFIDENTIAL FACT SHEET
NOT TO BE RELEASED

A. Illicit Drugs

1. a) Have you ever used (even one time) any illicit drugs of any kind within one (1) year before, or any time after, you first experienced your alleged ACCUTANE®-related injury(ies)?"

Yes _____ No _____

- b) If "Yes", identify each substance and state when you first and last used it.

- B. To the best of your knowledge, have you ever experienced, or been told by a doctor or other healthcare professional, that you have, may have or had any of the following at any time in your life (circle all that apply)?

<u>Symptom/Condition</u>	<u>Yes</u>	<u>No</u>	<u>Unsure</u>
Alcoholism			
Depression			
Eating disorders (anorexia, bulimia, etc.)			
Hepatitis			
HIV/AIDS			
Mental disorders			
Oral Herpes (canker sores), Herpes Zoster, Shingles			
Psychiatric problems			
Suicidal ideation			
Syphilis			

- C. *(If you are claiming psychiatric injuries as a consequence of Accutane):* To the best of your knowledge, have you ever experienced, or been told by a doctor or other healthcare professional, that you have, may have or had any of the following at any time in your life (circle all that apply)?

<u>Symptom/Condition</u>	<u>Yes</u>	<u>No</u>	<u>Unsure</u>
Anorexia			
Anxiety			

Bulimia			
Catatonic behavior			
Decrease or increase in appetite, lasting more than a few days.			
Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)			
Delusions			
Depersonalization (being detached from oneself)			
Depressed mood ,lasting more than a few days.			
Derealization (feelings of unreality)			
Difficulty concentrating or mind going blank, lasting more than a few days.			
Diminished ability to think or concentrate, or indecisiveness, lasting more than a few days.			
Disorganized speech			
Distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli), lasting more than a few days.			
Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)			
Fatigue or loss of energy, lasting more than a few days.			
Fear of losing control or going crazy			
Feelings of hopelessness			
Feelings of worthlessness or excessive or inappropriate guilt (not merely self-reproach or guilt about being sick), lasting more than a few days.			
Flat Affect			
Flight of ideas or subjective experience that thoughts are racing			
Hallucinations			
Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation			

Inflated self-esteem or grandiosity			
Insomnia, lasting more than a few days.			
Intense fear of gaining weight or becoming fat, even though underweight			
Irritability, lasting more than a few days.			
Low self-esteem, lasting more than a few days.			
Marked and persistent fear of social or performance situations together with either intense anxiety during such situations or the avoidance of such situations			
Markedly diminished interest or pleasure in all, or almost all activities, lasting more than a few days.			
More talkative than usual or pressure to keep talking, lasting more than a few days			
Panic attacks			
Phobias			
Psychomotor agitation or retardation			
Psychosis or psychotic			
Recurrent thoughts of death (not just fear of dying)			
Restlessness or feeling keyed up or on edge together with anxiety			
Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month)			
Sleep disturbance (difficulty following or staying asleep, or restless unsatisfying sleep), lasting more than a few days.			
Suicidal ideation			
Suicide attempt or a specific plan for committing suicide			

- D. *(If you are claiming psychiatric injuries as a consequence of Accutane):* If you responded "yes" to anything in C. above, please identify/state the condition(s), the date of onset, any medication prescribed to treat the condition(s), and the name of the physician or other person who made the diagnosis or informed you of the condition(s) and their address if not otherwise herein provided.

Condition(s): _____
 Onset date and medication: _____
 Name and address of physician or other person: _____

Condition(s): _____
 Onset date and medication: _____
 Name and address of physician or other person: _____

Condition(s): _____
 Onset date and medication: _____
 Name and address of physician or other person: _____

Condition(s): _____
 Onset date and medication: _____
 Name and address of physician or other person: _____

E. *(If you are claiming psychiatric injuries as a consequence of Accutane):* To the best of your knowledge, have your parents, grandparents, children or siblings ever experienced or been diagnosed with, or been told by a doctor or other healthcare professional, that they have, may have or had any of the following (circle all that apply), set forth the name of the individual and their relationship to you next to each condition(s) circled?

<u>Symptom/Condition</u>	<u>Name of Individual</u>	<u>Relationship</u>
Depression		
Schizophrenia		
Bipolar Disorder		
Manic Depression		
Psychosis		
Suicide		
Suicide Attempt		
Eating Disorder (Anorexia Bulimia)		
Anxiety		
Panic Attacks		
Personality Disorder		
Dissociative Disorder		
Mood Disorder		

Post-traumatic stress disorder		
Obsessive compulsive disorder		
Phobias		

CERTIFICATION

I certify under penalty of perjury that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, that I have supplied all the documents requested in part VIII of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Print Name

Signature

Date

Print Name
(Loss of Consortium Plaintiff)

Signature

Date

**LIST OF TOPICS FOR ELECTRONIC DOCUMENTS
FOR DISCOVERY FROM PLAINTIFFS' COMPUTERS
FOR PLAINTIFFS ALLEGING PSYCHIATRIC INJURIES**

In the context of these requests, "Accutane® user" is defined to mean each Plaintiff that ingested Accutane® and is alleging psychiatric injuries.

"Documents" is defined to include all documents and correspondence of any kind, including letters, notes, e-mails, instant messages, stories, poems, word processing files (including Word, WordPerfect, and Lotus Notes files), Excel files, PowerPoint files, and image files (including .tif, .pdf and .jpeg files). Defendants request these documents regardless of whether they are located on a hard drive, disk, CD-ROM, any other electronic storage format, or in a printout. URL or web addresses should be provided where available.

All requests shall be interpreted to exclude privileged communications between plaintiffs and their attorneys.

- I. Identify each and every computer used by the Plaintiffs by providing:**
- a. the name of the individual that owns the computer**
 - b. the current location of the computer**
 - c. approximate dates or timeframe Plaintiff used the computer**
 - d. whether the computer was searched for the information requested below.**
 - e. If the computer was not searched for the information requested below, provide the reason that it was not searched.**

Owner	Location	Dates of Use	Whether Searched	Reasons Not Searched

II. Accutane® User's Electronic Documents and Correspondence

Request
1. All documents authored by the Accutane® user. The time frame for this request is one year prior and up through and including the date of suicide. For attempted suicides, one year prior through one year after date of attempt.
2. All documents received by the Accutane® user. The time frame for this request is one year prior and up through and including the date of suicide. For attempted suicides, one year prior through

one year after date of attempt.
3. All chat room postings by the Accutane® user. The time frame for this request is one year prior and up through and including the date of suicide. For attempted suicides, one year prior through one year after date of attempt.
4. All college applications and essays (including drafts) written for college applications by the Accutane® user.
5. A printout of the Accutane® user's website "favorites" (websites frequently visited or book-marked).
6. All diaries, journals, calendars, or "to do" lists kept by the Accutane® user.
7. All photographs in which the Accutane® user appears, whether alone or with friends and/or family for the time period beginning one year prior to Plaintiff's(s') first or only prescription of Accutane® and ending two years after diagnosis of Plaintiffs'(s') alleged injuries.

III. Other Documents and Correspondence in Plaintiffs' Possession, Custody, or Control

A. Accutane® and other Medications

Request
1. All documents referring to Accutane®, excluding those gathered following retention of counsel.

2. All documents referring to ingestion of Accutane®, prescriptions for Accutane®, potential side effects of Accutane®, research performed regarding Accutane®, Accutane® warnings or labeling information, or adverse events experienced by users of Accutane®, excluding those gathered following retention of counsel.

3. All documents referring to treatment for acne or acne in general, excluding those gathered following retention of counsel.

4. All correspondence with any person who has taken Accutane® or that person's family or friends referring to Accutane® or this lawsuit, excluding those gathered following retention of counsel.

5. All documents referring to the Accutane® user's communications with physicians, family, or friends about Accutane®.

6. All documents referring to any medication – whether prescription or over-the-counter – taken by the Accutane® user, including medications taken before, during, or after Accutane® use. The time frame for this request is three years prior up to date of suicide. For attempted suicides, three years prior to and one year after date of attempt.

7. All documents referring to natural or organic supplements or vitamins taken by the Accutane® user. The time frame for this request is two years prior up to date of suicide. For attempted suicides, two years prior to and one year after date of attempt.

8. All documents referring to creatine use by the Accutane® user. The time frame for this request is two years prior up to date of suicide. For attempted suicides, two years prior to and one year after date of attempt.

9. All documents referring to steroid use by the Accutane® user. The time frame for this request is two years prior up to date of suicide. For attempted suicides, two years prior to and one year after date of attempt.

10. All documents referring to any other supplements taken by the Accutane® user. The time frame for this request is two years prior up to date of suicide. For attempted suicides, two years prior to and one year after date of attempt.

11. All documents referring to the Accutane® user's use of anti-depressants (for example Prozac, Paxil, Zoloft, or any SSRI (selective serotonin reuptake inhibitor) medication) or mood enhancers, whether prescription, over-the-counter, or natural or organic substances, at any time before, during, or after Accutane® use.

12. All chat room postings regarding Accutane®, including potential side effects from Accutane®, Accutane® warnings or labeling information, or adverse events experienced by users of Accutane®, that were posted by the Accutane® user or any documents referring or relating to the Accutane® user.

13. All documents (including correspondence) exchanged with any member of the RoAccutane® Action Group (RAGE), Liam Grant, or Congressman Bart Stupak.

14. All documents referring to the RoAccutane® Action Group (RAGE), Liam Grant, or Congressman Bart Stupak.
15. All information downloaded or otherwise obtained from any website regarding Accutane®, including potential side effects from Accutane®, Accutane® warnings or labeling information, or adverse events experienced by users of Accutane®, excluding those post-dating retention of counsel.
16. All newspaper articles, journal articles, studies or research regarding acne, Accutane®, potential side effects from Accutane®, Accutane® warnings or labeling information, or adverse events experienced by users of Accutane®, excluding those post-dating retention of counsel.
17. All documents referring to Defendants, including correspondence with Defendants, excluding those post-dating retention of counsel
18. All documents referring to any physical or mental condition experienced by the Accutane® user that is alleged to have been caused by his or her ingestion of Accutane®.
19. All documents referring to the causes of the Accutane® user's suicide or suicide attempt.
20. All prescriptions the Accutane® user or someone on his or her behalf filled on-line or attempted to fill on-line. The time frame for this request is six months prior to suicide. For attempted suicide, six months prior to attempt to one year after.
21. All documents referring to the Accutane® user's visits to or communications with physicians,

psychologists, or counselors.

B. Alcohol and Drug Use

Request

1. All documents referring to the use of alcohol (or alcoholism) by the Accutane® user and/or his or her family members.

2. All documents referring to the use of illegal drugs by the Accutane® user and/or his or her family members.

C. Financial Information

Request

1. All documents referring to the Accutane® user's feelings, concerns, or worries about his or her finances or ability to pay any bill. The time frame for this request is one year up to and including the date of suicide or attempted suicide. In addition, for attempted suicide, one year after attempt to extent refers to prior feelings and concerns.

2. All documents referring to the repossession of the Accutane® user's belongings or the threatened or actual eviction of the Accutane® user. The time frame for this request is one year prior to suicide or attempted suicide, and for attempted suicide, one year after attempt.

D. Educational Information

Request

1. All documents referring to the Accutane® user's education, including grades, schoolwork, homework, testing, violations of school rules, disciplinary

problems, delinquency, suspensions, expulsions, truancy, or absences (excused or unexcused). The time frame for this request is one year prior to suicide or attempted suicide, and for attempted suicide, one year after attempt for those plaintiffs' whose suicide or attempted suicide was 1999 or earlier. Two years prior for those whose suicide or suicide attempt was in 2000, and one year after for attempted suicide.

2. All documents referring to the Accutane® user's participation in extra-curricular, school, or after-school activities, including sports, clubs, newspaper staff, yearbook staff, service organizations, or social organizations. The time frame for this request is one year prior to suicide or attempted suicide, and for attempted suicide, one year after attempt for those plaintiffs' whose suicide or attempted suicide was 1999 or earlier. Two years prior for those whose suicide or suicide attempt was in 2000, and one year after for attempted suicide.

3. All documents referring to the Accutane® user's visits to or communications with school counselors or guidance counselors. The time frame for this request is one year prior to suicide or attempted suicide, and for attempted suicide, one year after attempt for those plaintiffs' whose suicide or attempted suicide was 1999 or earlier. Two years prior for those whose suicide or suicide attempt was in 2000, and one year after for attempted suicide.

4. All school papers or projects (including drafts) about acne, Accutane®, anxiety, depression, manic-depression, suicidal ideation, attempted suicide, suicide, psychosis (including seeing or hearing things that are not there), schizophrenia, cutting behavior, panic attacks, hyperventilation, eating disorders

(including anorexia and bulimia), obsessive behaviors (including self-mutilation or compulsive behavior), attention deficit disorder, attention problems, or any other mental health disorder or psychological problem.

5. All documents referring to the Accutane® user's selection of colleges, the Accutane® user's applications to colleges, the Accutane® user's plans for college, the Accutane® user's feelings or concerns about college (including going away to college), or the Accutane® user's feelings or concerns about his or her ability to get into college.

6. All documents referring to the Accutane® user going to college or leaving college.

E. Employment information

Request

1. All documents referring to the Accutane® user's employment, whether paid or unpaid, temporary or permanent, including salary, promotion, demotion, changes in hours, hiring, firing, quitting, performance reviews, absences (excused or unexcused), violations of workplace rules, suspensions, and altercations, disagreements or fights with co-workers or supervisors. The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide.

2. All documents referring to the Accutane® user changing employment. The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide.

3. All documents relating the Accutane® user's feelings about his or her

parents' employment. The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide.

4. All documents referring to the Accutane® user's participation in work-related or career-related clubs or organizations. The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide.

5. All documents referring to any workplace accident suffered by the Accutane® user or his or her claim for worker's compensation. The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide to extent the documents reflect mental or physical state, as well as other stressors.

6. All documents referring to the Accutane® user seeking or obtaining disability insurance (including failure to obtain disability insurance). The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide to extent the documents reflect mental or physical state, as well as other stressors.

7. All documents referring to the Accutane® user seeking or obtaining unemployment benefits (including failure to obtain unemployment benefits). The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide to extent the documents reflect mental or physical state, as well as other stressors.

8. All documents referring to the Accutane® user's plans for future employment. The time frame for this request is one year prior to suicide or attempted suicide, and one year after for

attempted suicide to extent the documents reflect mental or physical state, as well as other stressors.

F. Psychological information

Request
1. All documents referring to the Accutane® user experiencing anxiety, depression, manic-depression, suicidal ideation, attempted suicide, suicide, psychosis (including seeing or hearing things that are not there), schizophrenia, cutting behavior, panic attacks, hyperventilation, eating disorders (including anorexia and bulimia), obsessive behaviors (including self-mutilation or compulsive behavior), attention deficit disorder, attention problems, or any other mental health disorder or psychological problem before, during, or after Accutane® use.
2. All documents referring to the Accutane® user seeking or obtaining treatment for anxiety, depression, manic-depression, suicidal ideation, attempted suicide, suicide, psychosis (including seeing or hearing things that are not there), schizophrenia, cutting behavior, panic attacks, hyperventilation, eating disorders (including anorexia and bulimia), obsessive behaviors (including self-mutilation or compulsive behavior), attention deficit disorder, attention problems, or any other mental health disorder or psychological problems.
3. All documents referring to the Accutane® user experiencing any sleeping problem or eating problem (including sleeping or eating too much or too little or any changes in his or her sleeping or eating patterns).
4. All documents referring to anyone

in the Accutane® user's family experiencing anxiety, depression, manic-depression, suicidal ideation, attempted suicide, suicide, psychosis (including seeing or hearing things that are not there), schizophrenia, cutting behavior, panic attacks, hyperventilation, eating disorders (including anorexia and bulimia), obsessive behaviors (including self-mutilation or compulsive behavior), attention deficit disorder, attention problems, or any other mental health disorder or psychological problem (this request includes references to the Accutane® user having a "family history" of any of these problems or a "genetic" history of any of these problems).

5. All documents to or from the Accutane® user referring to the Accutane® user's friends, acquaintances, classmates or neighbors experiencing anxiety, depression, manic-depression, suicidal ideation, attempted suicide, suicide, psychosis (including seeing or hearing things that are not there), schizophrenia, cutting behavior, panic attacks, hyperventilation, eating disorders (including anorexia and bulimia), obsessive behaviors (including self-mutilation or compulsive behavior), attention deficit disorder, attention problems, or any other mental health disorder or psychological problem.

6. All documents referring to the death of any family members, friends, acquaintances, classmates, or co-workers of the Accutane® user.

7. All documents referring to suicide, thoughts of suicide, ways to commit suicide, plans for committing suicide, people who have committed suicide or attempted to commit suicide, or the desire to die.

8. All documents reflecting or

discussing significant purchases, sales, or giving away of possessions by the Accutane® user. The time frame for this request is six months prior to and up through and including the date of suicide or attempted suicide, and for attempted suicides, from the date of the attempt up to the present (relevant to damages, continued depression, etc.).

9. All documents referring to membership in support groups or attendance at support group meetings by the Accutane® user or a parent who has a claim.

10. All documents referring to the Accutane® user experiencing anger or needing to manage anger.

11. All documents referring to the Accutane® user's parents' knowledge or awareness about the Accutane® user's mood or mental state or efforts by anyone to address, change, or seek treatment for the Accutane® user's mood or mental disorder.

G. Interaction With Law Enforcement or Weapons

Request

1. All documents referring to the Accutane® user being stopped by police officers or other law enforcement, questioned by police officers or other law enforcement, or arrested by police officers or other law enforcement. The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide.

2. All documents referring to the Accutane® user being charged with or convicted of any offense. The time frame for this request is one year prior to suicide or attempted suicide, and one year after

for attempted suicide.

3. All documents referring to the Accutane® user being the victim of any crime (including theft, rape, assault, or other violent act), whether or not the perpetrator was charged with a crime. The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide.

4. All documents referring to the Accutane® user experiencing an emotionally, mentally or physically traumatic events such as rape or physical violence. The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide.

5. All documents referring to the Accutane® user instigating any fight – whether verbal or physical – or hitting, punching, or assaulting anyone. The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide.

6. All documents referring to weapons the Accutane® user owned, had access to, or used including but not limited to guns. The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide.

7. All documents referring to gun licenses, permits, gun club memberships, or hunting. The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide.

H. Relationships/Social activities

Request

1. All documents referring to the Accutane® user's relationship with his or her parents, including any expressions of feeling or emotion, any arguments, any fights, or any insults. The time frame for this request is three years prior to suicide or attempted suicide, and one year after for attempted suicide. It includes documents authored by Accutane® user or by others to extent refers or relates to Accutane® user.

2. All documents referring to the Accutane® user's relationships with his or her friends or romantic interests, including any expressions of feeling or emotion, any arguments, any fights, or any insults. The time frame for this request is three years prior to suicide or attempted suicide, and one year after for attempted suicide. It includes documents authored by Accutane® user or by others to extent refers or relates to Accutane® user.

3. All documents referring to pressure the Accutane® user felt to succeed in school, sports, extracurricular activities or work. The time frame for this request is three years prior to suicide or attempted suicide, and one year after for attempted suicide. It includes documents authored by Accutane® user or by others to extent refers or relates to Accutane® user.

4. All documents referring to pressure the Accutane® user felt to conform or be accepted by peers. The time frame for this request is three years prior to suicide or attempted suicide, and one year after for attempted suicide. It includes documents authored by Accutane® user or by others to extent refers or relates to Accutane® user.

5. All documents referring to the Accutane® user's family responsibilities, including chores, housework, and care for

siblings or other family members. The time frame for this request is three years prior to suicide or attempted suicide, and one year after for attempted suicide. It includes documents authored by Accutane® user or by others to extent refers or relates to Accutane® user.

6. All documents referring to conflicts in the Accutane® user's interpersonal relationships with family, friends, acquaintances, teachers, physicians, co-workers, or supervisors. The time frame for this request is three years prior to suicide or attempted suicide, and one year after for attempted suicide. Authored by Accutane® user or by others to extent refers or relates to Accutane® user.

7. All documents referring to the Accutane® user's relationships with members of the opposite sex or feelings about relationships with members of the opposite sex, including pursuit of relationships, beginning of relationships, dating, crushes, breakups or ending of relationships, unrequited feelings, or rejection. The time frame for this request is three years prior to suicide or attempted suicide, and one year after for attempted suicide. It includes documents authored by Accutane® user or by others to extent refers or relates to Accutane® user.

8. All documents referring to the Accutane® user's relationships with friends of the same sex or feelings about relationships with friends of the same sex. The time frame for this request is three years prior to suicide or attempted suicide, and one year after for attempted suicide. It includes documents authored by Accutane® user or by others to extent refers or relates to Accutane® user.

9. All documents referring to the Accutane® user's engaging in sexual

activity (including wanting to engage in sexual activity or not wanting to engage in sexual activity). The time frame for this request is three years prior to suicide or attempted suicide, and one year after for attempted suicide. Authored by Accutane® user or by others to extent refers or relates to Accutane® user.

10. All documents referring to parties or dances attended by the Accutane® user, hosted by the Accutane® user, or to which the Accutane® user was invited or wanted to be invited. The time frame for this request is three years prior to suicide or attempted suicide, and one year after for attempted suicide. It includes documents authored by Accutane® user or by others to extent refers or relates to Accutane® user.

11. All documents referring to sporting events attended by the Accutane® user or to which the Accutane® user was invited or wanted to be invited. The time frame for this request is three years prior to suicide or attempted suicide, and one year after for attempted suicide. Authored by Accutane® user or by others to extent refers or relates to Accutane® user.

12. All documents referring to the Accutane® user's hobbies or things he or she liked to do in his or her spare time. The time frame for this request is three years prior to suicide or attempted suicide, and one year after for attempted suicide. It includes documents authored by Accutane® user or by others to extent refers or relates to Accutane® user.

13. All documents referring to the Accutane® user stalking or being stalked by anyone. The time frame for this request is three years prior to suicide or attempted suicide, and one year after for attempted suicide. It includes documents

authored by Accutane® user or by others to extent refers or relates to Accutane® user.

I. Miscellaneous

Request

1. All diaries, journals, calendars, or “to do” lists that refer to the Accutane® user. The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide.

2. All documents referring to the Accutane® user’s travel or vacation plans (whether or not the Accutane® user actually followed through on the plans), including itineraries, tickets, confirmations, places visited, photographs, site-seeing, or persons accompanying the Accutane® user on any such trips or vacations. The time frame for this request is one year prior to suicide or attempted suicide, and one year after for attempted suicide.

**LIST OF TOPICS FOR ELECTRONIC DOCUMENTS
FOR DISCOVERY FROM PLAINTIFFS' COMPUTERS
FOR PLAINTIFFS ALLEGING SYSTEMIC INJURIES**

In the context of these requests, "Accutane® user" is defined to mean each Plaintiff that ingested Accutane® and is alleging systemic injuries.

"Documents" is defined to include all documents and correspondence of any kind, including letters, notes, e-mails, instant messages, stories, poems, word processing files (including Word, WordPerfect, and Lotus Notes files), Excel files, PowerPoint files, and image files (including .tif, .pdf and .jpeg files). Defendants request these documents regardless of whether they are located on a hard drive, disk, CD-ROM, any other electronic storage format, or in a printout. URL or web addresses should be provided where available.

All requests shall be interpreted to exclude privileged communications between plaintiffs and their attorneys.

- I. Identify each and every computer used by the Plaintiffs by providing:**
- a. the name of the individual that owns the computer
 - b. the current location of the computer
 - c. approximate dates or timeframe Plaintiff used the computer
 - d. whether the computer was searched for the information requested below.
 - e. If the computer was not searched for the information requested below, provide the reason that it was not searched.

Owner	Location	Dates of Use	Whether Searched	Reasons Not Searched

II. Accutane® User's Electronic Documents and Correspondence

Request
1. All college applications and essays (including drafts) written for college applications by the Accutane® user.
2. A printout of the Accutane® user's website "favorites" (websites frequently visited or book-marked), redacted for non-users favorites.
3. All diaries, journals, calendars, kept by the Accutane® user.
4. All photographs in which the Accutane® user appears, whether alone or with

friends and/or family for the time period beginning one year prior to Plaintiff's(s') first or only prescription of Accutane® and ending two years after diagnosis of Plaintiffs'(s') alleged injuries.

III. Other Documents and Correspondence in Plaintiffs' Possession, Custody, or Control

A. Accutane® and other Medications

Request
1. All documents referring to Accutane®, excluding those post-dating retention of counsel.
2. All documents referring to ingestion of Accutane®, prescriptions for Accutane®, potential side effects of Accutane®, research performed regarding Accutane®, Accutane® warnings or labeling information, or adverse events experienced by users of Accutane®, excluding those post-dating retention of counsel.
3. All documents referring to treatment for acne or acne in general, excluding those post-dating retention of counsel.
4. All correspondence with any person who has taken Accutane® or that person's family or friends referring to Accutane® or this lawsuit, excluding those post-dating retention of counsel.
5. All documents referring to the Accutane® user's communications with physicians, family, or friends about Accutane®.
6. All documents referring to any medication – whether prescription or over-the-counter – taken by the Accutane® user, including medications taken before, during, or after Accutane® use within the last ten years.
7. All documents referring to natural or organic supplements or vitamins taken by the

Accutane® user within the last ten years.
8. All documents referring to creatine use by the Accutane® user within the last ten years.
9. All documents referring to steroid use by the Accutane® user within the last ten years.
10. All documents referring to any other supplements taken by the Accutane® user.
11. All chat room postings regarding Accutane®, including potential side effects from Accutane®, Accutane® warnings or labeling information, or adverse events experienced by users of Accutane®, excluding those post-dating retention of counsel.
12. All documents (including correspondence) exchanged with any member of the RoAccutane® Action Group (RAGE), Liam Grant, or Congressman Bart Stupak, excluding those post-dating retention of counsel.
13. All documents referring to the RoAccutane® Action Group (RAGE), Liam Grant, or Congressman Bart Stupak, excluding those post-dating retention of counsel.
14. All information downloaded or otherwise obtained from any website regarding Accutane®, including potential side effects from Accutane®, Accutane® warnings or labeling information, or adverse events experienced by users of Accutane®, excluding those post-dating retention of counsel.
15. All newspaper articles, journal articles, studies or research regarding acne, Accutane®, potential side effects from Accutane®, Accutane® warnings or labeling information, or adverse events experienced by users of Accutane®, excluding those post-dating retention of counsel.
16. All documents referring to Defendants, including correspondence with Defendants,

excluding those post-dating retention of counsel.

17. All documents referring to any physical, emotional or other condition experienced by the Accutane® user that is alleged to have been caused by his or her ingestion of Accutane®.

18. All documents referring to the causes of the Accutane® user's alleged condition.

19. All prescriptions the Accutane® user or someone on his or her behalf filled on-line or attempted to fill on-line, within the last ten years.

20. All documents referring to the Accutane® user's visits to or communications with physicians.

B. Alcohol and Drug Use

Request

1. All documents referring to the use of alcohol (or alcoholism) by the Accutane® user or his or her family, within the last ten years.

2. All documents referring to the use of tobacco by the Accutane® user or his or her family, within the last ten years.

3. All documents referring to the use of illegal drugs by the Accutane® user or his or her family, within the last ten years.

C. Financial Information

Request

1. All documents referring to the Accutane® user's feelings, concerns, or worries about his or her finances or ability to pay any bill. The time frame for this request is six months prior to the date of first ingestion to the present.

D. Educational Information

Request
1. All documents referring to the Accutane® user's education, including grades, schoolwork, homework, testing, violations of school rules, disciplinary problems, delinquency, suspensions, expulsions, truancy, or absences (excused or unexcused). The time frame for this request is two years prior to the date of ingestion to the present.
2. All documents referring to the Accutane® user's participation in extra-curricular, school, or after-school activities, including sports, clubs, newspaper staff, yearbook staff, service organizations, or social organizations. The time frame for this request is two years prior to the date of ingestion to the present.
3. All documents referring to the Accutane® user's visits to or communications with school counselors or guidance counselors. The time frame for this request is two years prior to the date of ingestion to the present.
4. All school papers or projects (including drafts) about acne, Accutane® and any gastrointestinal or autoimmune disease, symptoms, conditions or disorders.
5. All documents referring to the Accutane® user's selection of colleges, the Accutane® user's applications to colleges, the Accutane® user's plans for college, the Accutane® user's feelings or concerns about college (including going away to college), or the Accutane® user's feelings or concerns about his or her ability to get into college.
6. All documents referring to the Accutane® user going to college or leaving college.

E. Employment information

Request
1. All documents referring to the Accutane® user's employment, whether paid or unpaid, temporary or permanent, including salary, promotion, demotion, changes in hours, hiring, firing, quitting, performance reviews, absences (excused or unexcused), violations of workplace rules, suspensions, and altercations, disagreements or fights with co-workers or supervisors. The time frame for this request is two years prior to the date of ingestion to the present.
2. All documents referring to the Accutane® user changing employment. The time frame for this request is two years prior to the date of ingestion to the present.
3. All documents referring to the Accutane® user's participation in work-related or career-related clubs or organizations. The time frame for this request is two years prior to the date of ingestion to the present.
4. All documents referring to any workplace accident suffered by the Accutane® user or his or her claim for worker's compensation. The time frame for this request is two years prior to the date of ingestion to the present.
5. All documents referring to the Accutane® user seeking or obtaining disability insurance (including failure to obtain disability insurance). The time frame for this request is two years prior to the date of ingestion to the present.
6. All documents referring to the Accutane® user seeking or obtaining unemployment benefits (including failure to obtain unemployment benefits). The time frame for this request is two years prior to the

date of ingestion to the present.

7. All documents referring to the Accutane® user's plans for future employment. The time frame for this request is two years prior to the date of ingestion to the present.

F. Psychological information

Request

1. All documents relating to any preexisting psychological problems. The time frame for this request is two years prior to the date of ingestion to the present.

2. All documents relating to psychological impact of claimed medical condition. The time frame for this request is two years prior to the date of ingestion to the present.

G. Interaction With Law Enforcement or Weapons

Request

1. All documents referring to the Accutane® user being arrested, charged with or convicted of any offense. The time frame for this request is two years prior to the date of ingestion to the present. This is subject to confidential treatment.

2. All documents referring to the Accutane® user being the victim of any crime (including theft, rape, assault, or other violent act), whether or not the perpetrator was charged with a crime. The time frame for this request is two years prior to the date of ingestion to the present. This is subject to confidential treatment.

3. All documents referring to the Accutane® user experiencing an emotionally, mentally or physically traumatic events such as rape or physical violence. The time frame for this request is two years prior to the date of ingestion to the present. This is subject to confidential treatment.

H. Relationships/Social activities

Request

1. All documents referring to the Accutane® user's relationship with his or her parents, including any expressions of feeling or emotion, any arguments, any fights, or any insults. The time frame for this request is six months prior to the date of first ingestion to the present.

2. All documents referring to the Accutane® user's relationships with his or her friends or romantic interests, including any expressions of feeling or emotion, any arguments, any fights, or any insults. The time frame for this request is six months prior to the date of first ingestion to the present.

3. All documents referring to pressure the Accutane® user felt to succeed in school, sports, extracurricular activities or work. The time frame for this request is six months prior to the date of first ingestion to the present.

4. All documents referring to pressure the Accutane® user felt to conform or be accepted by peers. The time frame for this request is six months prior to the date of first ingestion to the present.

5. All documents referring to the Accutane® user's family responsibilities, including chores, housework, and care for siblings or other family members. The time frame for this request is six months prior to

the date of first ingestion to the present.

6. All documents referring to conflicts in the Accutane® user's interpersonal relationships with family, friends, acquaintances, teachers, physicians, co-workers, or supervisors. The time frame for this request is six months prior to the date of first ingestion to the present.

7. All documents referring to the Accutane® user's hobbies or things he or she liked to do in his or her spare time. The time frame for this request is six months prior to the date of first ingestion to the present.

I. Miscellaneous

Request

1. All documents referring to the Accutane® user's travel or vacation plans. The time frame for this request is six months prior to the date of first ingestion to the present.