SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ATLANTIC COUNTY
MASTER CASE NO. ATL-L-2122-18

IN RE PHYSIOMESH LITIGATION (Flexible Composite Mesh)	:	CASE NO. 627 Civil Action **PLAINTIFF FACT SHEET**

_____ PLAINTIFF FACT SHEET OF _____

In completing this Plaintiff Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge, information and belief. If you cannot recall all of the details requested, please provide as much information as you can and then state that your answer is incomplete and explain why as appropriate. If any information you need to complete any part of the Fact Sheet is in the possession of your attorney, please consult with your attorney so that you can fully and accurately respond to the questions set out below. If you are completing the Fact Sheet for someone who cannot complete the Fact sheet themselves, please answer as completely as you can.

The Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. A completed Fact Sheet shall be considered interrogatory answers pursuant to Rule 4:17 of the Rules Governing the Courts of The State of New Jersey and as responses to requests for production pursuant to Rule 4:18 of the Rules Governing the Courts of The State of New Jersey. The questions and requests for production contained in the Fact Sheet shall be answered without objection. Whether you are completing this Plaintiff Fact Sheet for yourself or for someone else, the term "You" means the person who was treated with Physiomesh.

In completing this form please use the following definition: "healthcare provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, or other persons or entities involved in the diagnosis, care and/or treatment of you.

If you learn that any of your responses are incomplete or incorrect at any time, please supplement your responses to provide that information as soon as you become aware of this information. Any amended or corrected Plaintiff fact sheets must also include a new signed/dated verification.

I. CASE INFORMATION

A. Caption: _____

Docket No.: _____

B. Primary attorney contact (name, address, phone, and email):

_____

C. Full name of the person completing this form, if different from the person listed in the caption above, and the relationship of the person completing this form to the person listed in the caption above (Representative, Guardian, Other):

_____

II. PLAINTIFF INFORMATION

A. Name of individual implanted with Physiomesh _____
❑Male ❑Female

1. Date of birth: _____
2. Last four digits of Social Security No.: _____
3. Other names by which you have been known (from prior marriages or otherwise):

_____

B. Spouse name: _____

Loss of Consortium Claim? ❑Yes ❑No

C. Name of Estate Representative if individual implanted with Physiomesh is deceased or is not the filing party: _____

D. Have you ever filed for bankruptcy: ❑Yes ❑No

If so, identify the court/state of filing, caption of the case, docket number, and the date of filing and current status:

_____

_____

E. Address: _____

1. How long have you lived at your current address: _____

2. Provide the following for each of your prior residence from 2000 to the present:

Prior Address	Dates You Lived at Each Address

3. Where did you reside (city and state) at the time of your Physiomesh implantation surgery?

_____

4. Where did you reside (city and state) at the time of your Physiomesh explant or revision surgery (if applicable)?

_____

F. Identify the name, relationship, and current age of any person who currently resides with you:

1. Identify the name, relationship, and age (at that time) of any person who was residing with you at the time of your Physiomesh implantation surgery:

_____
_____
_____

2. Identify the name, relationship, and age (at that time) of any person who was residing with you at the time of the Physiomesh explant or revision surgery (if applicable):

_____
_____
_____

G. Have you ever been married? ❑Yes ❑No

If Yes, provide the following:

Spouse First and Last Name (Current)	Dates of Marriage	If Applicable: Reason for End of Marriage (e.g., death, divorce).	Spouse's Current Address and Telephone Number

H. Provide the full name and current age of each of your children, if any. Please provide the address of any child over the age of 18.

Name	Address	Age

Have you ever served in any branch of the military? ❑Yes ❑No

If Yes, please provide the following information:

Branch and dates of service, rank upon discharge, and the type of discharge you received:

_____

_____

1. Were you discharged from the military at any time due to your medical, physical, or psychiatric condition? ❑Yes ❑No

If Yes, state what that condition was:

_____

_____

I. In the 10 year period before implantation of the Physiomesh product, were you examined or treated for any medical condition at a Veterans' Affairs facility? ❑Yes ❑No

If Yes, identify the applicable Veterans' Affairs facility, the condition(s) treated, and approximate date(s) of treatment that condition was:

_____

_____

_____

J. Have you ever been convicted of, or pleaded guilty to, a felony and/or crime of fraud or dishonesty? ❑Yes ❑No

If Yes, please set forth the felony and/or crime, the date of the conviction or plea, the court, and docket number:

_____

K. Have you or anyone acting on your behalf had any communication, oral or written, with Johnson & Johnson, Ethicon, Inc., or their representatives, other than through your attorneys? ❑Yes ❑No ❑I Don't Know

If Yes, set forth the date of the communication, the method of communication, the name of the person with whom you communicated, and the substance of the communication between you and Johnson & Johnson, Ethicon, Inc., or their representatives:

_____

_____

_____

L. Did you respond to a television or media advertisement relating to hernia mesh lawsuits. ❑Yes ❑No

If Yes, state the date(s) (or approximate date if exact date not known) when you responded, the name of the entity you contacted, and the contact information for the entity you contacted (if you know):

_____

_____

_____

M. Are you now or have you ever been a member of Facebook, LinkedIn, Instagram, Twitter, or any other social media websites? ❑Yes ❑No

If Yes, provide the following information:

Name of Social Media Site(s)	Plaintiffs Username(s)/Handle(s)	Approximate Date(s) of Use

N. Identify any claim you have made, whether in the nature of a lawsuit , demand, or other request for damages, against any implanting or treating physician or hernia mesh manufacturer related to the implant at issue in this case, any other hernia mesh implants you have received, and/or the injuries you claim are caused by the Physiomesh implant.

_____

_____

O. Has Plaintiff entered into any agreement with any third party regarding funding of Plaintiff's civil action?

❑Yes ❑No

If YES please attach the Agreement. If the Agreement is not provided please provide a privilege log in accordance with Rule 4:10-2(e) setting forth the basis for not providing the Agreement (whether an objection on relevance grounds or privilege).

_____

_____

III. CONSORTIUM PLAINTIFF INFORMATION (IF APPLICABLE)

A. Name: _____

1. Other names (maiden name, prior marriages, etc.): _____

2. Date of birth: _____

3. Last four digits Social Security No.: _____

4. Address: _____

B. Are you now or have you ever been a member of Facebook, LinkedIn, Instagram, Twitter, or any other social media websites? ❑Yes ❑No

If Yes, provide the following information:

Name of Social Media Site(s)	Plaintiffs Username(s)/handle(s)	Approximate Date(s) of Use

C. Have you ever been convicted of, or pleaded guilty to, a felony and/or crime of fraud or dishonesty? ❑Yes ❑No

If Yes, please set forth the felony and/or crime, the date of the conviction or plea, the court, and docket number:

_____

_____

D. Please list the name and address of any healthcare providers you have seen for treatment for any injuries or symptoms alleged to be related to the loss of consortium claim, if any.

Provider Name, Address, and Specialty	Condition Treated	Approximate Dates of Treatment

IV. PHYSIOMESH DEVICE INFORMATION

A. Date of implant: _____

1. Reason the Physiomesh was implanted: _____
2. Physiomesh Size: _____
3. Lot Number: _____
4. Product Code: _____
5. Implanting Surgeon: _____
6. Medical Facility: _____
7. Additional products implanted during same procedure (if any):

_____

_____

B. For the Physiomesh product identified above, indicate if, prior to implantation, you received any written and/or verbal information or instructions, including any risks or complications that might be associated with the use of the product(s)?

❑Yes ❑No ❑Do not recall

If Yes:

1. Provide the date you received the written and/or verbal information or instructions:

_____

2. Identify by name and address the person(s) who provided the information or instructions:

_____

3. Describe in detail the information or instructions received:

_____

_____

_____

C. For the Physiomesh product identified above, did you receive post-operative surgical care instructions and/or restrictions that were provided either written and/or verbally?

❑Yes ❑No ❑Do not recall

If Yes:

1. Provide the date(s) you received the written and/or verbal instructions and/or restrictions:

_____

2. Identify by name, if known, and address the person(s) who provided the instructions and/or restrictions:

_____

_____

3. Describe the instructions and/or restrictions received:

_____

_____

4. If you have copies of the written instructions or restrictions you received, please separately upload a true and correct copy of any such documents with this completed Fact Sheet.

D. For the Physiomesh product that remains implanted in you:

1. Has any doctor or healthcare professional recommended removal or revision of the Physiomesh product(s)? ❑Yes ❑No

If Yes:

i. Identify by name and address the doctor who recommended removal:

_____

_____

ii. State your understanding of why the doctor recommended removal:

_____

2. Has any doctor or health care provider advised you not to have the Physiomesh product removed or revised? ❑Yes ❑No

If Yes:

i. Identify by name and address the doctor or healthcare professional who recommended not having the product removed/revised:

_____

_____

ii. State your understanding of why the doctor recommended that you not have the product removed/revised:

_____

_____

E. Have you filed a lawsuit or asserted any claim related to any other product implanted during the same procedure as the Physiomesh implant(s)? ❑Yes ❑No ❑N/A

If Yes, identify the claim/lawsuit asserted, the court, docket number, the date the claim/lawsuit was made, the injuries alleged, and the name/address of any counsel representing you in such claim/lawsuit:

_____

_____

V. REMOVAL/REVISION SURGERY INFORMATION

A. Date of revision/explant surgery(ies): _____

1. Description of revision/explant surgery(ies): _____
2. Revising/Explanting surgeon(s): _____
3. Medical Facility(ies):_____
4. Reason(s) you believe Physiomesh was removed/revised:

_____

_____

5. Does any medical treater, physician or anyone else on your behalf have possession of any portion of the Physiomesh product that was previously implanted in you and removed? ❑Yes ❑No ❑Do Not Know

If Yes, please state name and address of the person or entity having possession of same:

_____

_____

If No, do you know whether the removed portion of your Physiomesh product was destroyed? ❑Yes ❑No ❑Do Not Know

If Yes, describe how you know and identify who destroyed it:

_____

_____

VI. OUTCOME ATTRIBUTED TO DEVICE

A. Do you claim that you suffered injuries as a result of the implantation of Physiomesh?

❑Yes ❑No ❑Do Not Know

If Yes:

1. Please describe in detail the physical injury(ies) you claim were caused as a result of your use of the Physiomesh product:

_____

_____

_____

2. When did you first attribute these bodily injuries to the Physiomesh product?

_____

3. Please list all doctors or other healthcare providers you have seen for treatment of any of the alleged injuries listed above.

Provider Name, Address, and Specialty	Condition Treated	Approximate Dates of Treatment

B. Are you currently experiencing any physical or bodily injuries as a result of your Physiomesh product? ❑Yes ❑No

If Yes, please describe your current symptoms in detail if different than that which is set forth in Question A.1. above.

_____

_____

1. Are you currently seeing a doctor or healthcare provider for any of the injuries listed above? ❑Yes ❑No

2. Other than those doctors listed in the chart above, please list all doctors you are currently seeing for treatment of the injuries listed above:

Provider Name, Address, and Specialty	Condition Treated	Approximate Dates of Treatment

C. Do you claim that you have suffered a psychiatric or psychological injury requiring medical treatment as a result of the implantation of the Physiomesh Product? ❑Yes ❑No

If Yes:

1. Describe in detail the psychiatric or psychological injuries that you claim you are currently experiencing:

_____

_____

2. Are you currently seeing a doctor or healthcare provider for any of the psychiatric or psychological injuries listed above? ❑Yes ❑No

3. Other than those doctors listed in the chart above, please list all doctors you are currently seeing for treatment of the psychiatric or psychological injuries listed above:

Provider Name, Address, and Specialty	Condition Treated	Approximate Dates of Treatment

VII. ADDITIONAL HERNIA MESH PRODUCTS

Other than the Physiomesh product(s) that is the subject of your lawsuit, have you been implanted with any other hernia mesh products? ❑Yes ❑No

If Yes, please provide the following information:

1. Product Name(s):

_____

2. Date of implantation procedure(s) and name and address of implanting doctor(s):

_____

_____

3. Condition(s) sought to be treated through placement of the device(s):

_____

_____

4. To the best of your knowledge, did you experience any complications during the recovery period following the procedure(s)? ❑Yes ❑No

   If Yes, describe in detail any complications or difficulties you experienced during your recovery following the procedure(s):

_____

_____

5. Whether the product(s) remain implanted inside of you today? ❑Yes ❑No

   If no, identify when revised/removed and your understanding as to the reason for the revision/removal:

_____

_____

6. Have you filed a lawsuit or asserted any claim related to any other hernia mesh products? ❑Yes ❑No ❑N/A

   If Yes, identify the claim/lawsuit asserted, the court, docket number, the date the claim/lawsuit was made, the injuries alleged, and the name/address of any counsel representing you in such claim/lawsuit:

_____

_____

7. Has any doctor or health care provider advised you not to have the additional hernia mesh product removed or revised? ❑Yes ❑No

   If Yes:

   i. Identify by name and address the doctor or healthcare professional who recommended not having the product removed/revised:

_____

_____

8. State your understanding of why the doctor recommended that you not have the product removed/revised:

_____

_____

VIII. EDUCATION INFORMATION

A. Identify your educational background, starting with high school and including any technical or post-secondary education, in reverse chronological order (most recent education listed first):

Name of School	Address	Dates of Attendance	Degree, Diploma, or Certificate Awarded	Major or Primary Field

IX. EMPLOYMENT INFORMATION

A. Please provide the following information for your employment history from 2010 to the present in reverse chronological order (most recent employment listed first):

Employer Name	Address	Job Title/ Description of Duties	Dates of Employment	Annual Salary before taxes, or Rate of Pay

B. Do/Did any of the employment positions listed above require you to lift/carry/hold heavy objects? ❑Yes ❑No

If Yes, describe such lifting requirements, including in your response, without limitation, the frequency with which you are/were required to lift/carry/hold such objects.

_____

_____

C. In the 10 years prior to your Physiomesh implant, have you ever missed work for more than 10 consecutive days for reasons related to your health? ❑Yes ❑No

If Yes, describe the date(s) of any such absence and the health condition that prevented you from working.

_____

_____

X. ALLEGED DAMAGES

A. Are you claiming damages for lost wages? ❑Yes ❑No

If Yes:

1. Identify the time period you contend that you lost wages as a result of the injuries you contend resulted from the Physiomesh product:

_____

_____

2. What is the total amount of wages you are claiming you have lost as a result of your claims in this case as of the date this form is executed?

_____

_____

3. State the annual gross income you derived from your employment for each year, beginning five years prior to the implantation of the Physiomesh product until the present:

_____

_____

B. Are you or your spouse claiming lost out-of-pocket expenses? ❑Yes ❑No

If Yes:

a. As of the date this form is executed, what is the total amount of out-of-pocket expenses you are claiming you have lost as a result of your claims in this case?

_____

_____

b. Identify and itemize each individual out-of-pocket expense you are seeking to recover in this case which you contend resulted from the Physiomesh product:

_____

_____

XI. MEDICAL BACKGROUND

A. Current Height: _____ Current Weight: _____

B. Weight at the time you received the Physiomesh product(s) _____

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

- Current Smoker ❑
- Past Smoker ❑
- Non Smoker ❑

If you checked current or past smoker, indicate the tobacco products you have smoked (check applicable):

- o Cigarettes ❑
- o Cigars ❑
- o Pipe Tobacco ❑
- o Other ❑

If Other, please specify:

_____

If you checked current smoker, how much do you smoke?

_____

If you checked current smoker, how many years have you smoked? If you checked past smoker, approximately when did you quit?

_____

If you checked past smoker, how much did you smoke before you quit?

_____

If you checked past smoker, how many years did you smoke before you quit?

_____

D. Prior to the first Physiomesh implant, to the best of your knowledge, have you ever had:

Diabetes: ❑Yes ❑No

If Yes, what type and when diagnosed?

_____

_____

Adhesions or Adhesive Disease: ❑Yes ❑No

If Yes, describe (including date diagnosed and treatment received):

_____

_____

Connective Tissue Disorders (such as Ehlers-Danlos and Marfan's Syndrome)

❑Yes ❑No

If Yes, describe (including date diagnosed and treatment received):

_____

_____

Irritable Bowel Syndrome: ❑Yes ❑No

If Yes, when diagnosed?

_____

_____

Lupus: ❑Yes ❑No

If Yes, when diagnosed?

_____

_____

Auto Immune Disorder: ❑Yes ❑No

If Yes, identify (including date diagnosed and treatment received)

_____

_____

Anemia or other blood disorder: ❑Yes ❑No

If Yes, identify (including date diagnosed)

_____

_____

Respiratory disease, including Asthma, Emphysema, and/or COPD: ❑Yes ❑No

If Yes, identify (including date diagnosed):

_____

_____

Any disease of the gut, abdomen, intestines, or bowels: ❑Yes ❑No

If Yes, identify (including date diagnosed and treatment received):

_____

_____

Any abdominal surgery(ies): ❑Yes ❑No

If Yes, identify (including date of procedure):

_____

_____

Prescribed medication to treat constipation: ❑Yes ❑No

If Yes, identify the medication, who prescribed, and when prescribed:

_____

_____

Prescribed medication to treat bronchitis: ❑Yes ❑No

If Yes, identify the medication, who prescribed, and when prescribed:

_____

_____

Sought treatment for enlarged prostate or straining to urinate: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

Sleep Apnea: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

Conditions requiring use of Steroids, Immune Suppression or Chemotherapy: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

Ascites: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

Cystic fibrosis: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

Chronic lung infections: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

Collagen Disorders: ❑Yes ❑No

If Yes, identify the disorder, treatment received, provider(s) seen, and dates of treatment:

Fibromyalgia or other chronic pain condition: ❑Yes ❑No

If Yes, identify, describe the treatment received, provider(s) seen, and dates of treatment:

_____

_____

Fistula(s): ❑Yes ❑No

If Yes, identify the location, treatment received, provider(s) seen, and dates of treatment:

_____

_____

Bowel Obstruction: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

_____

_____

Bowel Perforation: ❑Yes ❑No

If Yes, identify the treatment received, provider(s) seen, and dates of treatment:

_____

_____

E. Other than the hernia(s) the Physiomesh or other hernia mesh product(s) identified in Section VII above was/(were) intended to treat, have you ever had any other hernia(s)? ❑Yes ❑No

If Yes:

1. Describe when each hernia was diagnosed:

_____

_____

2. Describe the location of each hernia:

_____

_____

3. Describe the type of hernia (if known):

_____

_____

4. Describe whether the hernia was repaired surgically (including the date of any such repair, the surgeon who performed the repair, and the facility where the repair was performed):

_____

_____

5. To the best of your knowledge, did you experience any complications during the recovery period following the procedure(s)? ❑Yes ❑No

If yes, describe in detail any complications or difficulties you experienced during your recovery following the procedure(s):

_____

_____

F. In chronological order, list any and all pelvic or abdominal surgeries and/or hospitalizations relating to the pelvic or abdominal region you have had in the 10 year period BEFORE implantation of the Physiomesh product(s); identifying by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved; and providing the approximate date(s) for each.

Doctor or Healthcare Provider Involved (including address)	Description of Surgery and/or Hospitalization	Approximate. Date

G. In chronological order, list any and all surgeries, procedures, or hospitalizations you had AFTER the implantation of the Physiomesh product(s); identifying by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved with each surgery or procedure; and provide the approximate date(s) for each.

Doctor or Healthcare Provider Involved (including address)	Description of Surgery and/or Hospitalization	Approximate. Date

H. Describe how, if at all, you contend your physical activities associated with daily living, physical fitness (including any weightlifting), household tasks, and employment-related activities have changed as a result of the implantation of the Physiomesh product.

_____

_____

I. For female plaintiffs, have you previously given birth? ❑Yes ❑No

If Yes:

1. How many births and dates of each birth?

_____
_____
_____
_____

2. If any of the births were by cesarean section, please state the number of cesarean section births:

_____
_____

J. List each prescription medication you have taken **for more than 45 consecutive days, within five years prior to the Physiomesh implant to the present,** giving the name and address of the pharmacy where you received/filled the medication, the reason you took the medication, and the approximate dates of use.

Prescription Medication	Name of Pharmacy and Address

K. Identify the name and address of any pharmacy where you received/filled any prescription medication within the last 10 years.

Name of Pharmacy	Address

XII. LIST OF MEDICAL PROVIDERS

A. To the extent not already provided above, list all treating physicians or other medical providers you have seen for the period of 10 years prior to the first Physiomesh implant to the present, including, but not limited to, all primary care physicians, internists, general surgeons, psychiatrists, urologists, endocrinologists, rheumatologists, or any other specialists. You do not have to list mental healthcare providers if you are not claiming psychological injuries as part of this lawsuit.

Provider Name, Address and Specialty	Condition Treated	Approximate Date of Treatment

XIII. INSURANCE INFORMATION

A. Provide the following information for any past or present medical insurance coverage within the last 10 years:

Insurance Company (Name and Address)	Policy Number	Name of Policy Holder/Insured (if different than you)	Approx. Dates of Coverage

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

❑Yes ❑No ❑Do Not Know

C. If Yes, please state when the denial occurred, the name of the life insurance company, and the company's reason for denial: To the best of your knowledge, have you been approved to receive or are you receiving Medicare benefits due to age, disability, condition or any other reason or basis?

❑Yes ❑No ❑Do Not Know

If Yes, please specify the date on which you first became eligible:

_____

_____

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

XIV. PRIOR CLAIM INFORMATION

A. Have you filed a lawsuit or made a claim within the last 10 years prior to implant to present, other than in the present suit relating to any bodily injury? ❑Yes ❑No

If Yes, please specify the following:

1. Court in which suit/claim filed or made: _____
2. Case/Claim Number: _____
3. Nature of claim and specific injuries alleged:

_____

_____

B. Have you applied for workers' compensation (WC), Social Security disability (SSI or SSD) benefits, or other state or federal disability benefits within the last 10 years prior to implant to present? ❑Yes ❑No

If Yes, please specify the following:

1. Date (or year) of application: _____

2. Type of benefits sought: (check applicable):

   - Workers' Compensation ❑
   - Social Security Disability ❑
   - Other ❑

If Other, please specify the type of benefits sought:

_____

_____

3. Agency/Insurer from which you sought the benefits:

_____

4. The nature of the claim and specific injuries/disability alleged:

_____

5. Whether the claim was accepted or denied: _____

6. Whether you are currently receiving any benefits as a result of the claim:

_____

_____

7. Identify the name and address of the entity most likely to have records concerning your claim:

_____

_____

8. If applicable, the name and address of your employer against whom the claim was filed:

_____

_____

XV. FACT WITNESSES

A. Identify all persons whom you believe may possess information concerning your injury(ies) and current medical conditions, other than your healthcare providers, and please state their name, phone number, address, and his/her/their relationship to you:

Name	Address and Phone Number	Relationship to You	Information you Believe Person Possesses

XVI. IDENTIFICATION OF DOCUMENTS AND OTHER ELECTRONICALLY STORED INFORMATION

A. For the period beginning three years prior to implantation of the Physiomesh product(s) to present, please identify all research, including on-line research, you have conducted regarding the subjects of this litigation, including the implantation of the Physiomesh product(s), the injuries and/or damages you claim resulted from the implantation of the Physiomesh product(s), or your medical or physical condition. Identify date, time, and source, including any websites visited. Research conducted to understand the legal and strategic advice of your counsel is not considered responsive to this request.

_____

_____

_____

XVII. DOCUMENT REQUESTS

A. State whether you have any of the following documents in your possession, custody, and/or control. If you do, please separately upload a true and correct copy of any such documents with this completed Fact Sheet.

1. If you were appointed by a court to represent the plaintiff in this lawsuit, produce any documents demonstrating your appointment as such.

   ❑Not Applicable

   ❑The documents are attached

   ❑I have no documents

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

   ❑Not Applicable

   ❑The documents are attached

   ❑I have no documents

3. Produce any communications (sent or received) in your possession, which shall include materials accessible to you from any computer, phone, or smartphone on which you have sent or received such communications, discussing the Physiomesh and/or the additional hernia mesh product(s), your alleged injuries, or subject litigation, including but not limited to all letters, e-mails, blogs, publicly accessible Facebook posts, text messages, tweets, newsletters, etc. sent or received by you. Research conducted to understand the legal and strategic advice of your counsel is not considered responsive to this request.

   ❑Not Applicable

   ❑The documents are attached

   ❑I have no documents

4. Produce all documents (including journal entries, lists, memoranda, notes, diaries), photographs, medical records, videos, DVDs or other media, including all copies, discussing or referencing the subjects of this litigation including the Physiomesh and/or the additional hernia mesh product(s) or the injuries and/or damages you claim resulted from the Physiomesh and/or the additional hernia mesh product(s) from the date of the implantation of the Physiomesh and/or the additional hernia mesh product(s) to present, including but not limited to the injuries for which you seek relief in this lawsuit. Research conducted to understand the legal and strategic advice of your counsel is not considered responsive to this request.

   ❑Not Applicable

   ❑The documents are attached

   ❑I have no documents

5. Produce any Physiomesh and/or the additional hernia mesh product packaging, labeling, advertising, or any other Physiomesh and/or the additional hernia mesh product product-related items in your possession, custody or control.

   ❑Not Applicable

   ❑The documents are attached

   ❑I have no documents

6. Produce all documents concerning any communication between you and the Food and Drug Administration (FDA) or between you and any employee or agent of Johnson & Johnson or Ethicon, Inc. regarding the Physiomesh and/or the additional hernia mesh product(s) at issue, except as to those communications which are attorney client/work product privileged.

   ❑Not Applicable

   ❑The documents are attached

   ❑I have no documents

7. To the extent you have documents in your possession identified in response to Question II(L) above, produce such documents.

   ❑Not Applicable

   ❑The documents are attached

   ❑I have no documents

8. Produce any and all documents in your possession, custody or control reflecting, describing, or in any way relating to any instructions or warnings you received prior to implantation of the Physiomesh and/or the additional hernia mesh product(s) concerning the risks and/or benefits associated with the Physiomesh and/or the additional hernia mesh product(s) you received.

   ❑Not Applicable

   ❑The documents are attached

   ❑I have no documents

9. If you underwent surgery to explant in whole or in part the Physiomesh and/or the additional hernia mesh product(s) that you received: produce any and all documents in your possession, custody or control aside from documents that may have been generated by experts retained by your counsel for litigation purposes, relating to any evaluation of the Physiomesh and/or the additional hernia mesh product(s) and any other material that was (were) surgically removed from you.

   ❑Not Applicable

   ❑The documents are attached

   ❑I have no documents

10. If you claim lost wages or lost earning capacity, copies of your federal and state tax returns for the two years prior to implantation of the Physiomesh and/or the additional hernia mesh product(s) to the present.

    ❑Not Applicable

    ❑The documents are attached

    ❑I have no documents in my possession

11. If you claim lost wages or lost earning capacity, copies of all documents supporting that claim.

    ❑Not Applicable

    ❑The documents are attached

    ❑I have no documents in my possession

12. If you are seeking compensation for lost out-of-pocket expenses, copies of all documents supporting that claim.

    ❑Not Applicable

    ❑The documents are attached

    ❑I have no documents in my possession

13. Any photographs, digital images, video, or other media in your possession, custody, or control which show the hernia that was repaired with the Physiomesh and/or the additional hernia mesh product(s) and/or any physical condition or alleged injury you contend was caused by the Physiomesh and/or the additional hernia mesh product(s).

    ❑Not Applicable

    ❑The documents are attached

    ❑I have no documents

14. All documents in your possession, custody or control concerning payment by Medicare on the injured party's behalf relating to the injuries claimed in this lawsuit, including but not limited to Interim Conditional Payment summaries and/or estimates prepared by Medicare or its representatives regarding payments made on your behalf for medical expenses relating to the subject of this litigation.

    ❑Not Applicable

    ❑The documents are attached

    ❑I have no documents in my possession

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

SWORN VERIFICATION

By providing the information set forth herein, I declare under penalty of perjury subject to all applicable laws, that I have carefully reviewed the final copy of this Plaintiff Fact Sheet and verified that all of the information provided is true and correct to the best of my knowledge, information and belief.

_____
Signature of Plaintiff

_____
Date

SWORN VERIFICATION OF CONSORTIUM PLAINTIFF

By providing the information set forth herein, I declare under penalty of perjury subject to all applicable laws, that I have carefully reviewed the final copy of this Plaintiff Fact Sheet and verified that all of the information provided is true and correct to the best of my knowledge, information and belief.

_____
Signature of Consortium Plaintiff

_____
Date