

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE: E. I. DU PONT DE
NEMOURS AND COMPANY C-8
PERSONAL INJURY LITIGATION

Case No. 2:13-md-2433

JUDGE EDMUND A. SARGUS, JR.
Magistrate Judge Elizabeth P. Deavers

This document relates to: ALL ACTIONS.

EXHIBIT 1
TO CASE MANAGEMENT ORDER NO. 4

**IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION**

MDL No. 2433

In Re: E. I. du Pont de Nemours and Company C-8 Personal Injury Litigation

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. If being filled out on behalf of someone who has died or is a minor, the questions relate to the deceased person or minor asserting claims in the lawsuit. If all the details requested cannot be recalled, please provide as much information as you can. The Plaintiff Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. *ADDITIONALLY, ALL ASPECTS OF THIS PLAINTIFF FACT SHEET ARE DESIGNATED AS CONFIDENTIAL AND COVERED BY THE AGREED PROTECTIVE ORDER (Docket No. 27).*

I. CASE INFORMATION

1. **Caption:** _____ **Date:** _____

2. **Docket No.:** _____

3. **Plaintiff's Attorney and Contact information:**

4. **Do you claim that you are a member of the class in *Jack W. Leach, et al. v. E. I. du Pont de Nemours and Company*, Civ. No. 01-C-608 (Cir. Ct. Wood Co. W. Va.)? (please select one):** Yes No

II. PLAINTIFF INFORMATION

5. Name: _____

6. State any other name(s), including maiden names, that you have used and when:

7. Date of birth: _____ 8. Place of birth: _____

10. Social Security No.: _____

11. Current Height: _____ 12. Current Weight: _____ 13. Gender: _____

14. If Currently Married:

a. Spouse's Name: _____

b. Spouse's date of birth: _____ c. Date of Marriage _____

c. Spouse Occupation: _____

15. Are you making a loss of Consortium claim in this case?.....Yes No

16. If Previously Married:

| Previous Spouse | Dates of Marriage |
|-----------------|-------------------|
| | |
| | |

17. If you are completing this Fact Sheet in a representative capacity (on behalf of the estate of a deceased person or a minor), state:

a. Your name and address: _____

b. Your relationship to the deceased or the minor plaintiff:

c. Date of death (if applicable): _____

18. Current and Prior Residences since 1950:

| Current and Prior Addresses | Dates You Lived At This Address |
|-----------------------------|---------------------------------|
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19. Identify all schools you attended, starting from and including high school:

| Name of School | Address | Dates of Attendance | Degree Awarded | Major or Primary Field |
|----------------|---------|---------------------|----------------|------------------------|
| | | | | |
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20. Please provide the following information for your employment history over the past ten (10) years:

| Employer/Company | Address | Occupation/ Job Title/ Job Description | Dates of Employment |
|------------------|---------|--|---------------------|
| | | | |
| | | | |

21. **WITHOUT LIMITATION TO DATE RESTRICTIONS**, please provide the following information for **ANY** employment you have had with duPont or at duPont's Washington Works Plant in Wood County, West Virginia:

| Employer/Company | Address | Occupation/ Job Title | Dates of Employment |
|------------------|---------|--------------------------|---------------------|
| | | | |
| | | | |

22. Have you ever served in a branch of the military? Yes No

If yes, state the dates, the branch of service, duties, and highest rank/position attained:

23. Have you ever been convicted of a felony or non-traffic related other crime? Yes No

If yes, state the date, the court, and nature of the crime:

24. If you ever filed a lawsuit or made a claim, other than the present lawsuit (and other than the original *Leach* class action lawsuit against DuPont involving this same C8 drinking water exposure), relating to any bodily injury or illness, explain where and when the lawsuit or claim was filed, the injuries claimed, and the names of the adverse parties:

25. Have you ever had direct communication with DuPont, or any known employee of DuPont, regarding C8 contamination or injuries you claim you suffered because of alleged C8 exposure?Yes No

If yes, please identify the form of communication, the approximate time of communication, the nature of the communication, and the individual(s) with whom the communication was made.

III. ALLEGED C8 EXPOSURE

26. If you have, since 1950, consumed drinking water from any of the following water sources for at least one year prior to December 4, 2004, list the approximate dates you used each such source: (check all that apply and list years)

- City of Belpre (OH) from _____ to _____
- Little Hocking Water Association (OH) from _____ to _____
- Lubeck Public Service District (WV) from _____ to _____
- Mason County Public Service District (WV) from _____ to _____
- Village of Pomeroy (OH) from _____ to _____
- Tappers Plains- Chester Water District (OH) from _____ to _____
- DuPont Washington Works Plant in Wood County, West Virginia from _____ to _____
- General Electric Plastics Plant in Wood County, West Virginia from _____ to _____
- Private Drinking Water Well _____ from _____ to _____

27. Identify whether you have used for at least one year prior to December 4, 2004, any of the following sources of drinking water since 1950 and list the dates you used each source:

| | Ever Used (Y/N)? | When used/Frequency of Use: | Where obtained: |
|-----------------|------------------|-----------------------------|-----------------|
| Private Well | | | |
| Bottled Water | | | |
| Water at Job | | | |
| Other (explain) | | | |

28. If you have ever used a water filter at your home for your drinking water, state the approximate dates used (if known), type (if known), manufacturer (if known), and who furnished/paid for the filter (if known):

29. If you have ever participated in a bottled water replacement program, state the approximate dates you participated (if known), who sponsored/ran the program (if known), and who furnished/paid for the water you received from the program (if known):

IV. DISEASE ATTRIBUTED TO C8 EXPOSURE

30. Did you participate in the C-8 Heath Project? YES No

If yes, state how you participated, and provide your study or other identification number (if known). _____

31. Do you claim to suffer from a PROBABLE LINK disease as established under the Leach settlement? YES No (check all that apply)

- Kidney Cancer Testicular Cancer Thyroid Disease
 Ulcerative Colitis Pregnancy-Induced Hypertension Preeclampsia
 Medically-Diagnosed High Cholesterol

32. For each PROBABLE LINK disease checked above, list the disease, identify the DIAGNOSING doctor, that doctor's full address, and the approximate date of diagnosis.

| DISEASE | DIAGNOSING DOCTOR (name and full address) | DATE OF DIAGNOSIS |
|---------|---|-------------------|
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33. For each disease checked above, list the disease, identify the TREATING doctors or facility(ies) (*if different than the diagnosing doctor*), the full address, and the date(s) of treatment.

| DISEASE | TREATING DOCTOR and/or FACILITY (name and full address <i>if different than the diagnosing doctor</i>) | DATE(S) OF TREATMENT |
|---------|---|----------------------|
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34. For each disease checked above, identify the dates and locations of any blood tests, tissue samples, pathology reports, and/or any other medical testing that you know to be related to that specific disease.

| Type of Test | Approximate Date of Test | Test Provider (Doctor, Hospital, of Clinic) |
|--------------|--------------------------|---|
| | | |
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35. For each disease checked above, have you ever discussed with any of the diagnosing or treating physicians you identified above for such disease(s) whether they believed that such disease(s) may have been caused by C8/PFOA? YES No

If yes, (identify which disease if more than one) please provide the name(s) and address(es) and the approximate date(s) for any such physician who told you that your disease(s) may have been caused by C8/PFOA. _____

36. List all medications taken over the 5 years before and 5 years after the date you claim that you were first diagnosed with the disease(s) for which you are making a claim in this lawsuit, and for each medication state the following:

| Medication | Pharmacy | Prescribing Physician | Reason for Medication |
|------------|----------|-----------------------|-----------------------|
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V. PAST HISTORY

37. Do you currently smoke? YES No

- a. (If yes) How much? _____/day For how long? _____ yrs.
- b. What brand do/did you smoke (or type if other than cigarettes)? _____

38. Have you ever smoked? YES No

- a. (If yes) How much? _____/day Approximate dates? _____
- b. What brand do/did you smoke (or type if other than cigarettes)? _____

39. Do you drink alcohol? YES No

- a. (If yes) Approximately how often, how much, and what? _____

40. Biological parents' names and current ages/dates of birth (if deceased, note date and cause):

| Name | Date of Birth | If Deceased, date of death | If Deceased, cause of death |
|------|---------------|----------------------------|-----------------------------|
| | | | |
| | | | |

41. Biological siblings' names and current ages/dates of birth (if deceased, note date and cause):

| Name | Date of Birth | If Deceased, date of death | If Deceased, cause of death |
|------|---------------|----------------------------|-----------------------------|
| | | | |
| | | | |
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42. Biological children's names and current ages/dates of birth (if deceased, note date and cause):

| Name | Date of Birth | If Deceased, date of death | If Deceased, cause of death |
|------|---------------|----------------------------|-----------------------------|
| | | | |
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43. Identify whether you are aware if any of your biological relatives listed above has suffered from any of the disease(s) for which you are pursuing a claim in this case, and if yes, which relative, which disease(s), and approximately when did they first have this disease.

44. Have you applied for workers' compensation, social security, or state or federal disability benefits within the past twenty (20) years? YES No

If Yes, then as to each application, separately state:

Date (or year) of application: _____

Type of benefits: _____

Nature of claimed injury/disability: _____

Period of disability: _____

Amount awarded: _____

Basis of your claim: _____

Claim/docket number (if applicable): _____ Was claim denied? YES No

VI. OTHER CLAIMS

45. Are you claiming damages for lost wages: YES No

If yes, for what time period: _____

If yes, what was your approximate wage during this time: _____

46. Are you claiming damages for out-of-pocket costs: YES No

If yes, please provide a brief description of the costs incurred and/or claimed, including the approximate amount (if known):

VII. LIST OF ALL TREATING PHYSICIANS OR OTHER HEALTH PRACTITIONERS FOR THE PERIOD OF 10 YEARS PRIOR TO THE FIRST DIAGNOSIS OF THE C8 PROBABLE LINKED DISEASE(S) IDENTIFIED ABOVE, INCLUDING ALL PRIMARY CARE PHYSICIANS, FAMILY PHYSICIANS, OR ANY OTHER SPECIALISTS

Primary Care Physicians or Family Physicians:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Reason for Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Reason for Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Reason for Treatment: _____

Other Physicians or Health Care Practitioners:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Reason for Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Reason for Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Reason for Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Reason for Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Reason for Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Reason for Treatment: _____

Attach additional pages as needed to identify other health care providers you have seen.

AUTHORIZATIONS

Provide ONE (1) SIGNED ORIGINAL copy of the records authorization forms attached as Ex. A for each provider identified. These authorizations will authorize the records vendor selected by the parties to obtain those records identified in the authorizations from the providers identified within this Plaintiff Fact Sheet.

RECORDS

Provide those records in your possession which you used and/or relied upon to complete this form and/ or which support and/or relate to your claimed injuries or damages, your participation in the C-8 Health Project, or your claims for the C8 probable linked disease(s) alleged and/or described herein.

VERIFICATION

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

Print Name