IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

In re: PARAQUAT PRODUCTS LIABILITY LITIGATION	**Case No. 3:21-MD-3004-NJR**
This Document Relates to All Cases	**MDL No. 3004**

CASE MANAGEMENT ORDER NO. 7

ROSENSTENGEL, Chief Judge:

The undersigned issues this seventh Case Management Order to implement the form and application of the Plaintiff's Assessment Questionnaire, hereby known as "PAQ" (*see* Exhibit 1) and the Plaintiff's Fact Sheet, hereby known as "PFS" (*see* Exhibit 2) in this litigation.

The PAQ includes document requests and three written authorizations for the release of records, "Authorizations" (*see* Exhibit 3). The PFS includes document requests and six additional written authorizations for the release of records that are not included with the PAQ "Authorizations" (*see* Exhibit 4).

This Order applies to all Plaintiffs and Defendants and their counsel in: (a) all actions transferred to *In re*: Paraquat Products Liability Litigation ("MDL 3004") by the Judicial Panel on Multidistrict Litigation ("JPML") pursuant to its Orders dated June 8, 2021, June 17, 2021, June 21, 2021, June 24, 2021, and July 7, 2021, and (b) to all related actions directly filed in or removed to this Court.

The Court hereby adopts the PAQ and requires that it be completed by all filed Plaintiffs in the MDL. The Court anticipates later issuing an Order regarding trial case

selection and will require the PFS to be completed by those Plaintiffs. The Special Master shall work with the parties and propose guidelines and protocols for the PFS at the time of trial selection as ordered by this Court.

This Order also directs Special Master Randi Ellis, pursuant to her appointment in CMO No. 4, to propose an implementation order for the Court to review by no later than **September 10, 2021**, that shall accomplish the following:

1. Establish deadlines for the PAQ and its required document production.
2. Establish rules and requirements for the execution of authorizations.
3. Establish guidelines determining the substantial completeness of the PAQ.
4. Establish both a deficiency and objection resolution protocol for the PAQ.
5. Establish a service protocol for the PAQ.
6. Establish an efficient online platform for data management for the entry, storage, and maintenance of the PAQ that will be available to counsel for all parties; and
7. Advise the Court on the status of the Proposed Defendants' Fact Sheet (DFS) and its implementation of the DFS.

The Court sincerely appreciates the efforts of all counsel and reminds the parties to continue to work efficiently and collaboratively with Special Master Ellis.

IT IS SO ORDERED

DATED: September 3, 2021

Nancy J. Rosenstengel

NANCY J. ROSENSTENGEL
Chief U.S. District Judge

EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

This Document Relates to:	)	Case No. 3:21-md-03004-NJR3:21-md-03004-NJR
[member case name and number]	)	
IN RE: PARAQUAT PRODUCTS LIABILITY LITIGATION	)	MDL No. 3004

PLAINTIFF'S ASSESSMENT QUESTIONNAIRE (PAQ)

You are required to provide the following information regarding yourself, or for each individual on whose behalf you are asserting potential legal claims. Each question must be answered in full, to the best of your ability taking into account the Plaintiff's physical and mental condition at the time that the Plaintiff or the representative is completing this form.

In completing this Plaintiff Assessment Questionnaire, you are under oath and must provide information that is true and correct to the best of your knowledge. If you do not know or cannot recall the information needed to answer a question, please indicate so in response to the question. You may supplement your responses if you learn that they are incomplete or incorrect. For each question, where the space provided does not allow for a complete answer, please attach additional sheets so that all answers are complete. If you attach additional sheets, clearly label the sheets with which question the sheet pertains to.

Please do not leave any questions unanswered or blank; if a question does not apply, respond "N/A".

I. REPRESENTATIVE CAPACITY

If completing this Questionnaire in a representative capacity of the Plaintiff/Decedent on whose behalf this action was filed, please complete the following**:**

A. Your Name (First, Middle, Last): _____

B. Home address: _____

C. Relationship to the person on whose behalf you are answering these questions:

_____

II. PERSONAL INFORMATION

A. Full name (First, Middle, Last): _____

B. Date of birth: _____

C. Social Security Number: _____

D. Medicare and/or Medicaid Number: _____

III. RESIDENTIAL HISTORY

Identify every place you have lived for ten (10) years before the onset of the symptoms of the injury(ies) you are claiming in this lawsuit:

Street	City	State	From Month(s)/Year(s)	To Month(s)/Year(s)

IV. EMPLOYMENT HISTORY

A. Identify every job you have had for the ten (10) years prior to the onset of the symptoms of the injury(ies) you are claiming in this lawsuit:

Employer Name	From Month(s)/ Year(s)	To Month(s)/ Years(s)	City	State	Supervisor Names	Job Description(s)	Paraquat Exposure (Y/N)

V. UNION MEMBERSHIP

A. Have you ever been a member of any labor union? Yes: _____ No: _____

B. If yes, state the name and city/state of each such union.

Name of Union	City/State

VI. MILITARY SERVICE

A. Have you served in the military in any capacity? Yes: _____ No: _____

B. If yes, identify the dates of such service, branch, and the highest rank attained.

From Month(s)/ Year(s)	To Month(s)/ Year(s)	Branch	Rank Attained

VII. FAMILY HISTORY

A. Has a close blood relative of yours (parents, siblings, or children) been diagnosed with Parkinson's disease or any other nervous system disorder or neurodegenerative disorder? Yes: _____ No: _____

B. If yes, please provide the following information:

Relationship to You	Diagnosis	Date of Diagnosis

VIII. MEDICAL HISTORY

A. Identify the names of all primary care providers you have seen from ten (10) years prior to the onset of any symptoms of the injury(ies) you are claiming in this lawsuit; and

B. Identify any neurologists who have treated you for a neurological disorder, including Parkinson's Disease, since birth.

Primary Care Provider/ Neurologist Name	Name of Facility	City	State	Diagnosis	Month/Year of Diagnosis

C. Has any medical provider ever determined that the injury(ies) you are claiming in this lawsuit was caused by and/or associated with your exposure to an agricultural, industrial, or other toxic chemical? Yes _____ No ____

Provider Name	Name of Facility	City	State	Name of Chemical	Month/Year

D. Identify the names of any medical providers you have seen since the onset of symptoms of the injury(ies) you are claiming in this lawsuit. To the extent you received care at a hospital or other institution, provide the name of the hospital or other institution.

Provider Name	Name of Facility	City	State	Month(s)/Year(s) of Treatment	Description of Injuries/Symptoms	Description of Treatment

E. Has a medical provider ever ordered genetic testing related to your claimed injury(ies) in this lawsuit?

Yes _____ No _____

If yes, identify the type of testing and the results of that testing. _____

_____

IX. INSURANCE AND CLAIM INFORMATION

1. Have you filed a disability claim relating to your injures claimed in this lawsuit?

   Yes _____ No _____

   a. If Yes, please indicate: SSD? _____ SSI? _____ Private Insurer? _____

   b. If private insurer claim, please identify the company: _____

2. Year the claim was filed: _____

3. Was your application denied? Yes ____ No _____

   a. If Yes, what was the reason for denial? _____

   b. If Yes, what was the month/year of denial? _____

4. Nature of disability giving rise to filing: _____

5. Who were you determined to be disabled by: (check all that apply):

Social Security	☐
Medical Provider	☐
Insurance company	☐

6. As you fill out this questionnaire, are you still disabled? Yes_____ No _____

X. FARMING HISTORY

A. Did you engage in farming? Yes _____ No _____

B. If yes, please answer the following:

Month(s)/ Year(s)	Name of Business	City	State	Crops Planted or Harvested	Agricultural Chemicals You Applied	How You Applied the Chemicals

XI. TRAINING, CERTIFICATION, LICENSING

A. Have you ever received any formal training, certification or licensing regarding agricultural chemicals of any kind, including, but not limited to paraquat? ("Formal" training includes instruction or tutorial provided by an employment supervisor.)

Yes _____ No _____

B. If yes, please answer the following:

Type of Training/ Certification/Licensing	Month(s)/Year(s) of Completion	Person or Entity Providing Training/Certification/Licensing

XII. WORKPLACE PARAQUAT EXPOSURE

A. For each time you were exposed to paraquat (ie: handled, mixed, applied, assisted in application, sprayed or otherwise came in contact with) while working, provide the following information:

USES	Identify Specific Job Title During Exposure	Approx. Dates of Use (Month(s)/Year(s))
USE #1		
USE #2		
USE #3		
USE #4		

B. For each Use identified above, please provide the following additional information:

USES	Method of Use/Exposure (How Was it Used/Applied)?	Used on Approx. How Many Acres?	Approx. How Many Gallons Used?	How Many Days Per Year on Avg. Was it Applied?	Individual/Entity Who Sold or Supplied You with Paraquat
USE #1					
USE #2					
USE #3					
USE #4					

1. For each Use identified above, if you know, please identify as much of the below information as possible:

	Name of Product	City of Specific Location's Use	State	Crops Used on	Strength or Concentration of Product	What Other Product (If Any) Was Product Mixed With
USE #1						
USE #2						
USE #3						
USE #4						

2. For each Use identified above, if you know, please identify the following:

	Records of Purchase of Product? (Y/N?)	**Name of Person/Entity Holding Applicator License**	**License Number (If Known)**
USE #1			
USE #2			
USE #3			
USE #4			

3. For any of the Uses identified above, if you know, please identify as much of the below information as possible:

   a. Whether a label was affixed to any of the containers of the paraquat:

      Yes_____ No _____Do Not Recall _____

   b. If Yes, whether any safety-related information was provided in addition to the label:

      Yes_____ No _____ Do Not Recall _____

   c. If Yes, then did you review and follow any instructions or recommendations included on the label or within the safety-related information:

      Yes_____ No _____

   d. If Yes, please approximate the month/year you remember reviewing: _____

4. What personal protective equipment did you wear when exposed to paraquat:

Personal Protective Equipment	Check All That Apply	Used During Which Exposure as identified by Use # above or ALL
1. Dust/Mist Filtering or NIOSH/MSHA-Approved Pesticide Respirator	☐	
2. Rubber or Waterproof Gloves	☐	
3. Chemical-resistant or Waterproof Footwear and Socks	☐	
4. Chemical-resistant Headgear for Overhead Exposure or Face Shield	☐	

5. Disposable Suit/Coveralls	☐	
6. Long-sleeved Shirt	☐	
7. Long Pants	☐	
8. Protective Eyewear	☐	
9. Rubber or Waterproof Apron	☐	
10. Any Other Form of Personal Protective Equipment (Identify_____)	☐	

XIII. OTHER PARAQUAT EXPOSURE

A. Do you claim that you were exposed to paraquat and/or a paraquat-based product in a location other than your workplace? Yes _____ No _____
(If no, move to section XIII below.)

B. If Yes, please complete the following information for the exposure to paraquat identified above:

Your location(s) at time of paraquat exposure	**Where did your paraquat exposure originate?**	**Your proximity from where the paraquat originated**	**City**	**State**	**From Month(s)/ Year(s)**	**To Month(s)/ Year(s)**	**Description of paraquat exposure**

XIV. USE OF OTHER INDUSTRIAL/AGRICULTURAL CHEMICALS

A. Have you ever been exposed to a "restricted use" agricultural chemical (other than paraquat)?

Yes _____ No _____ I Do Not Recall _____

B. If Yes, please identify the following for each "restricted use" agricultural chemical (other than paraquat) that you handled, mixed, applied, assisted in application, sprayed or otherwise came in contact:

Product Name	Approx. Date Range of Use (Month(s)/Year(s))	Quantity Used	Details of Use

1. Did you wear any personal protective equipment when exposed to other restricted use agricultural chemical(s) identified above? Yes _____No _____

2. If Yes, please provide the following information: (Check all that apply)

Personal Protective Equipment	Applicable?	With Which (or all) Chemicals Identified Above?
1. Dust/Mist Filtering or NIOSH/MSHA-Approved Pesticide Respirator	☐	
2. Rubber or Waterproof Gloves	☐	
3. Chemical-resistant or Waterproof Footwear and Socks	☐	
4. Chemical-resistant Headgear for Overhead Exposure or Face Shield	☐	
5. Disposable Suit/Coveralls	☐	
6. Long-sleeved Shirt	☐	
7. Long Pants	☐	
8. Protective Eyewear	☐	
9. Rubber or Waterproof Apron	☐	
10. Any Other Form of Personal Protective Equipment (Identify_____)	☐	

XV. SUBSTANCE HISTORY

A. Have you ever used methamphetamines? Yes___ No____

If yes, please identify date range (month(s)/year(s)): _____

XVI. OCCUPATIONAL WELDING HISTORY

A. Have you ever been employed as a welder or welded for more than 50% of your workday? Yes___ No____

B. If Yes, identify the following:

From Year	To Year	City	State	Frequency	Did your welding take place in confined space? (Y/N)	Type of welding	Type of metal involved	Type of equipment used

XVII. HISTORY OF HEAD INJURIES

A. Have you ever suffered from any head injuries that required medical treatment and/or concussions diagnosed by a medical professional? Yes___ No____

B. If Yes, please provide the following information:

Month/Year of head injury/ concussion	Cause of injury/concussion	Diagnosis	Name of Health Care Provider	City	State

XVIII. KNOWLEDGE REGARDING LAWSUIT

A. Do you have in your possession any documents or information (other than anything obtained through or from your attorneys) that the onset of the symptoms of the injury(ies) you are claiming in this lawsuit are connected in any way to your exposure to paraquat? Yes____ No____

If Yes, please identify such documents or information: _____
_____

XIX. WAGE LOSS

A. If you claim that you have been unable to work because of your claimed injury(ies) in this lawsuit, please provide the following information:

Unable to Work From Month/Year	Unable to Work To Month/Year	Name of Employer	City	State

XX. RELEVANT PERSONS/WITNESSES

A. Identify any person whom you believe has firsthand personal knowledge about your exposure and/or claimed injury(ies):

Name of Witness	City	State	Relationship to You

XXI. COMMUNICATIONS REGARDING DEFENDANTS

A. Have you, or anyone acting on your behalf, directly communicated with, interviewed, or obtained statements from (1) any of the Defendants (i.e. Syngenta Crop Protection LLC, Syngenta AG, Chevron USA Inc., or any other defendant named in your specific lawsuit) regarding the allegations in the lawsuit or (2) from *any person or entity* specifically about Defendants' business with respect to paraquat, the health effects of paraquat, and/or the usage of and practices associated with paraquat in the United States, since the filing of this lawsuit? **This question excludes privileged communications exclusively with your counsel, exclusively between you and your counsel, and between your counsel and experts retained in this litigation.**

Yes___ No____

B. If you answered yes, for each communication referenced above, please identify the following:

Name of Defendant Or Other Person/Entity	Month/Year of Communication

If Other, please identify: _____

XXII. BANKRUPTCY

1. Since you first were exposed to paraquat, have you filed for bankruptcy? Yes ___ No__

    a. If Yes, provide the following information:

Month/Year You Filed for Bankruptcy	Court Where Bankruptcy was Filed	Name of Your Bankruptcy Attorney, if any	Case Number	Name of Trustee	Month/Year Bankruptcy was Closed/Finalized

XXIII. DOCUMENTATION

Please attach to this Questionnaire the Documents described below that are in your possession, custody or control. For purposes of this Plaintiff's Assessment Questionnaire, you are not required to obtain records from third party entities (such as insurance carriers or medical providers):

A. Any and all Documents showing any type of medical care, services, and/or consultation you have received from (1) all primary care providers you have seen from ten (10) years before you began experiencing symptoms for the injury(ies) you claim in this lawsuit through the present; (2) any neurologists who have treated you for a neurological disorder since birth; (3) any providers you have treated you in relation to any brain or head injury identified above; and (4) all providers you have seen since the onset of Parkinson's Disease symptoms.

B. Documents in your possession that show proof of your employment history, including Documents indicating the names of and your formal affiliations with any limited liability corporations, partnerships, or other business entities.

C. All Documents related to any training, certification, or licensing that any person or entity, including you or any of your employers or supervisors, have received related to Restricted Use Chemicals, including but not limited to paraquat.

D. All Documents (including, without limitation, receipts, invoices, labeling, instructions, warnings, precautions, and marketing materials) relating to your purchase, use, handling, and/or disposal of agricultural chemicals, including but not limited to paraquat, and/or the purchase, use, handling, and/or disposal of Restricted Use Chemicals at farms at which you worked.

E. All Documents, including all publications or studies, from which you, your family members, or your personal acquaintances have relied upon to learn about the relationship between Parkinson's disease and paraquat.

F. All Documents, including public records, identifying, referring, or relating to surveillance, investigation, or other information gathering performed by or on behalf of Plaintiff relating to any of the Defendants in this action, Defendants' employees (current or former), and Defendants' disclosed witnesses in this case. This Request includes Documents obtained from any source.

G. All Documents in your possession that refer or relate to Defendants in this action or Defendants' employees (current or former). This Request includes but is not limited to surveys, questionnaires, promotional materials, or other Documents or materials exchanged between you and Defendants.

H. Documents reflecting, depicting, or describing any piece of farm equipment or implement you used to apply paraquat at any time, including without limitation the

tractor, tank, and sprayer (including nozzles). For row crops, this request includes the farm equipment or implement(s) used to prepare, or to plant any crop planted on, acreage treated with paraquat, including without limitation the planter, drill, any type of cultivator or harrow, and fertilizer application equipment. This request encompasses documents such as, without limitation, photographs, videos, equipment manuals or instructions, proof of purchase, warranties, and/or maintenance or repair records.

I. Inspection of any equipment or implement responsive to Request H (directly above) that remains in your possession.

J. All Documents identified in your answers to any interrogatories directed to you in this case and all Documents on which you relied in responding to any questions directed to you in this case.

XXIV. AUTHORIZATIONS

Please complete, sign, and provide the following Authorizations, as applicable:

- Authorization for Release of Health Information (Attachment A). For this authorization, include an authorization for release of records for all Health Care Providers listed in this Fact Sheet, including those listed in Sections VII and XVI.
- Authorization to Disclose Employment Information (Attachment B). For this authorization, include an authorization for release of records for all employers listed in Section III.
- Request Pertaining to Military Records (Attachment C).

XXV. VERIFICATION

Pursuant to 28 U.S.C. § 1746, I declare that all the information provided in connection with this Plaintiff Assessment Questionnaire is true and correct to the best of my knowledge, information, and belief. I further declare that I have engaged in the best efforts to identify, locate, and supply all of the information and documents requested in this Plaintiff Assessment Questionnaire. I acknowledge that I may supplement the above responses if necessary.

I was exposed to the chemical paraquat. I declare and affirm this based on the information and evidence included in this form including the dates, locations, and exposure information that I have supplied above.

I declare under penalty of perjury that the foregoing is true and correct.

Dated on _____.

Name _____
(please print)

_____
Signature

EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

This Document Relates to:	)	Case No. 3:21-md-03004-NJR3:21-md-03004-NJR
[member case name and number]	)	MDL No. 3004
IN RE: PARAQUAT PRODUCTS LIABILITY LITIGATION	)	

PLAINTIFF'S FACT SHEET

This Plaintiff's Fact Sheet is a legal document. You are required to provide the following information regarding yourself, or for each individual on whose behalf you are asserting potential legal claims. Each question must be answered to the best of your ability taking into account the Plaintiff's physical and mental condition at the time that the Plaintiff or the representative is completing this form.

In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge including using documents in your possession. If you do not know the answer, please indicate that in response to the question. In answering the questions below, you should never guess. You may supplement your responses if you learn that they are incomplete or incorrect.

For each question where the space provided does not allow for a complete answer, please attach additional sheets so that all answers are complete. If you attach additional sheets, clearly label the sheets according to the question to which each sheet pertains. Please do not leave any questions unanswered or blank. If a question does not apply, please respond "Not Applicable" or "N/A."

You must complete this Fact Sheet for any claim that you wish to assert against the Syngenta or Chevron Defendants.

After completing this Fact Sheet, you must sign the Fact Sheet on the last page. Your signature certifies that you have answered this Fact Sheet under oath, that your answers are true and accurate to the best of your knowledge.

If you have any questions about this Fact Sheet, you should speak with your attorneys.

I. REPRESENTATIVE CAPACITY

A. If you are completing this Fact Sheet in a representative capacity of the Plaintiff/Decedent on whose behalf this action was filed, please complete the following:

1. Your Name (First, Middle, Last): _____

2. Home address: _____

3. Your relationship to the person upon whose behalf you have completed this Fact Sheet (*e.g.*, parent, guardian, estate administrator):

_____

[If you are completing this Questionnaire in representative capacity, please respond to the following questions on behalf of the person who you represent.]

II. PERSONAL INFORMATION

A. Full Name (First, Middle, Last): _____

B. Maiden Name: _____

C. Date of birth: _____

D. Social Security Number: _____

E. Medicare, Medicaid, and/or Tricare Claim numbers: _____

F. Race: _____

G. Ethnicity (Hispanic/Non-Hispanic):_____

H. Identify the following information for every place you have lived for the last ten (10) years for at least one year, through the present. If you claim that you were exposed to paraquat at any place you lived for less than a year, please include that address as well.

Address (or best approximation)	**Years you lived at address (ex. 1/1998-6/2002)**	**All Persons who lived at address and relationship to you**	**Paraquat exposure? (Y/N)**

III. EMPLOYMENT HISTORY

A. Identify 25 years of employment history by either: (1) every place of employment for the last 25 years; or (2) if you are retired, every place of employment for the 25 years before you retired.

Employer Name	Approximate Date Range of your Employment (Month/Year)	City/State	Supervisor Name(s)	Brief Description of Job Responsibilities	Paraquat Exposure? (Y/N)

B. Have you ever applied for worker's compensation, social security disability benefits, private disability benefits, or state or federal benefits?

Yes _____ No_____

C. If yes, then as to each application, please provide the following information, including the dollar amount of benefits (if any) received:

Approximate date claim was filed	Name of agency	Nature of claimed injury or disability	Ultimate disposition of claim	Amount of benefits received, if any

IV. UNION MEMBERSHIP

A. Have you ever been a member of any labor union?

Yes _____ No_____

B. If yes, state the name and address of each such union, job to which it applied, and the approximate date range of your membership.

Name of Union	**City/State where Union is located**	**Job to which it pertained**	**Approximate date range in year(s)of membership**

V. MILITARY SERVICE

A. Have you served in the military in any capacity?

Yes _____ No_____

B. If yes, identify the branch of the military, the highest rank attained, the years of service, and the locations where you were stationed.

Branch of military	Highest rank attained	Approximate date range of service (Month/Year)	Locations stationed

VII. LITIGATION HISTORY

A. Have you ever filed a civil lawsuit? (This does not apply to this pending suit or other suits relating to domestic relationships, divorces, or child custody.)

Yes _____ No_____

B. If yes, then as to each lawsuit, separately state the nature of the case and claims, where the case was filed, and your attorney's name.

_____

VIII. FAMILY HISTORY

A. To the best of your recollection and knowledge, identify all of the following diseases that your parents, siblings, grandparents, or child of yours has been diagnosed with. (Check all that apply)

Disease	Parent, Sibling, Grandparent, or Child with Diagnosis?
1. Parkinson's Disease	☐
2. Parkinsonism	☐
3. Alzheimer's Disease	☐
4. Dementia	☐
5. Lewy Body Dementia	☐
6. Huntington's Disease	☐
7. Wilson's Disease	☐
8. Tourette Syndrome	☐
9. Ataxia	☐
10. Chorea	☐
11. Dystonia	☐
12. Multiple System Atrophy	☐
13. Myoclonus	☐
14. Progressive Supranuclear Palsy	☐
15. Tardive Dyskinesia	☐
16. Crohn's Disease	☐
17. Glioblastoma	☐
18. Colorectal Cancer	☐

19. Lung Cancer	☐
20. Ovarian Cancer	☐
21. Gaucher's Disease	☐
22. Any other neurodegenerative disease	☐
23. Any other neurological disease or disease of the brain, spine or nerves	☐

IX. MEDICAL SERVICES

A. If you have been diagnosed with Parkinson's Disease, please identify the name(s) of any and all Health Care Providers[1] who have diagnosed you with or treated you for it. For each provider identified, provide the following information:

Provider Name	Date(s) of Medical Care, Services, Consultation	City/State of Practice

B. If you have been diagnosed with Parkinsonism, please identify the name(s) of all Health Care Providers who have diagnosed you with or treated you it. For each provider identified, provide the following information:

Provider Name	Date(s) of Medical Care, Services, Consultation	City/State of Practice

[1] For the purposes of this Fact Sheet, "Health Care Provider" is defined as physical therapist or physical therapy department, rehabilitation specialist, physician, osteopath, homeopath, chiropractor, or other persons or entities involved directly in the evaluation, diagnosis, care, and/or treatment of your physical health.

C. If you have been diagnosed with or treated for renal failure or kidney failure or any other injury you claim as an injury in this lawsuit, please identify the name(s) of all Health Care Providers who have diagnosed you with or treated you for that injury. For each provider identified, provide the following information:

Provider Name	Injury/Diagnosis	Date(s) of Medical Care, Services, Consultation	City/State of Practice

D. Prior to your involvement in this litigation, have you undergone genetic testing, including, but not limited to genetic testing related to your Parkinson's disease or Parkinsonism diagnosis?[2]

Yes _____ No_____

E. If yes, identify the results of that testing.

_____

F. To the best of your knowledge and recollection, identify (1) the names of all primary Health Care Providers you have seen in the 25 years prior to your symptoms and/or diagnosis with the injury(ies) you are claiming in this litigation; (2) any neurologists you have seen in your lifetime; (3) the names of any Health Care Providers you have seen in relation to any brain or head injury; (4) the names of any Health Care Providers you have seen in relation to any chemical or toxic exposure; and (5) the names of all Health Care Providers you have seen for any serious illness or injury since the time you began treatment for the injury(ies) you are claiming in this lawsuit. To the extent you received care at a hospital or other

[2] For purposes of this Fact Sheet, "genetic testing" excludes genetic testing that was performed only for genetic variants associated with breast cancer, ovarian cancer, pancreatic cancer, prostate cancer, or Lynch syndrome, as well as genetic testing that did not include testing for any specific genetic variants but instead solely examined your likely ancestry and/or ethnicity.

institution, provide the name of the hospital or other institution. For each provider or entity identified, provide the following information.

Provider Name	Approximate Date(s) of Medical Care, Services, Consultation	Nature of Medical Care, Services, Consultation	Name and Location of Facility

XI. FARMING HISTORY

A. Please provide the following information for all years in which you were actively engaged in farming or the application of Agricultural Chemicals.[3]

City/ State	Business Name (if applicable)	Your Role	Year(s)	Acres	Crops Planted or Harvested	Agricultural Chemicals Used	Identity of All Persons Actively Engaged in Farming or Application of Agricultural Chemicals at Location (incl. Supervisors)

[3] For the purposes of this Fact Sheet, "Agricultural Chemicals" is defined as any and all herbicides, pesticides, and insecticides used at each of the locations identified in your responses.

B. Have you ever been a member of an agricultural or farming organization?

Yes _____ No_____

C. If yes, state the name and city/state of each organization and the years of your membership in each such organization.

_____

XII. TRAINING, CERTIFICATION, LICENSING

A. Identify all formal training, certification or licensing you have received regarding Agricultural Chemicals of any kind, including but not limited to Paraquat, as well as the dates and provider of such training, certification or licensing. "Formal" training includes instruction or tutorial provided by an employment supervisor.

Type of Training / Certification / Licensing	Year	Provider of Training/Certification/Licensing

B. Have you ever been licensed to apply Restricted Use Pesticides?

Yes _____ No_____

C. If yes, provide the following information for each license received.

Issuing State	Type of License	Years for Which License was Active	Type of Training Related to License	Year of Training/License	Provider of Training

XIII. PARAQUAT PURCHASE HISTORY

A. Did you ever purchase paraquat?

Yes _____ No_____

B. If yes, provide the following information with respect to each year you purchased paraquat.

Year	Product Name	Manufacturer Name	Number of Purchases	Amount Purchased	Seller or Distributor

C. If you purchased paraquat, what are the benefits that you understood paraquat had at the time(s) that you purchased it?

_____

D. If you purchased paraquat, why did you choose to purchase paraquat?

_____

E. If you purchased paraquat, were there alternatives available when you purchased paraquat? If so, please list. _____

XIV. PARAQUAT USE AND EXPOSURE

This section requires you to provide information about your exposure to paraquat during mixing, loading, or application of the product, as well as during field reentry or other potential instances of exposure. Each potential type of exposure (*e.g.*, mixing/loading, application, reentry) is treated separately to allow you to provide information as accurately as possible.

A. Have you ever personally mixed and/or loaded paraquat?

Yes _____ No_____

If no, please move on to XIV.F.

B. For each time you mixed and/or loaded Paraquat, provide the following information to the best of your knowledge and recollection.

Employer and job title			
Approximate date range			
Frequency of mixing/loading during this period			
Name of Farm/Ranch and City/State			
Mixing method			
Loading method			
Name(s) of paraquat products used during period			
Name(s) of product manufacturer (if known)			
Formulation[4]			
Strength or Concentration[5]			
Quantity of Concentrate Mixed or Loaded			
Other product(s), if any, mixed with product			
Name of individual or entity that sold or provided product			
Did you purchase this paraquat product yourself? (Y/N)			
Do you possess records of purchase of this paraquat product? (Y/N)			
Name of person or entity holding license to use Restricted Use Pesticides			
Issuing state for license to use Restricted Use Pesticides			
License number			
Names and of others who witnessed you mixing and/or loading			

[4] For example, liquid formulation or granules.

[5] For example, 240 g/l or 360 g/l.

C. If you answered yes to XIV.A, did you wear personal protective equipment during every instance you mixed and/or loaded paraquat?

Yes _____ No_____

D. If no, please state the approximate number of times you mixed and/or loaded paraquat without wearing any personal protective equipment.

_____

E. For each instance you wore personal protective equipment while mixing and/or loading paraquat, please identify which, if any, of the following you wore: (Check all that apply)

Personal Protective Equipment	Applicable?
1. Dust/Mist Filtering or NIOSH/MSHA-Approved Pesticide Respirator	☐
2. Rubber or Waterproof Gloves	☐
3. Chemical-resistant or Waterproof Footwear and Socks	☐
4. Chemical-resistant Headgear for Overhead Exposure or Face Shield	☐
5. Disposable Suit/Coveralls	☐
6. Long-sleeved Shirt	☐
7. Long Pants	☐
8. Protective Eyewear	☐
9. Rubber or Waterproof Apron	☐
10. Any Other Form of Personal Protective Equipment	☐

1. If you checked the box for "Any Other Form of Personal Protective Equipment" above, please describe the personal protective equipment used.

_____

F. Have you ever personally applied paraquat?

Yes _____ No_____

If no, please move on to XIV.K.

G. If yes, for each time you applied paraquat, provide the following information to the best of your knowledge and recollection.

Employer and job title			

Approximate Year(s)			
Frequency of application during this period			
Name of Farm/Ranch and City/State			
Average quantity applied			
Total acreage to which product was applied			
Application method & duration			
Purpose			
Crops and weeds to which product was applied			
Equipment used			
Nozzle type			
Application pressure			
Boom or application height			
Name(s) of paraquat products used during period			
Name(s) of product manufacturer (if known)			
Formulation[6]			
Strength or Concentration[7]			
Tank Mix[8]			
Name of individual or entity that sold or provided paraquat product			
Did you purchase this paraquat product yourself? (Y/N)			
Do you possess records of purchase of paraquat product? (Y/N)			
Name of person or entity holding license to use Restricted Use Pesticides			
Issuing state for license			

[6] For example, liquid formulation or granules.

[7] For example, 240 g/l or 360 g/l.

[8] Identify all components of the tank mixture containing paraquat, including but not limited to adjuvants, surfactants, spray modifiers, utility agents, or other pesticides.

License number			
Names and of others who witnessed you applying paraquat			

H. If you answered yes to XIV.F, did you wear any personal protective equipment during every instance you applied paraquat?

Yes _____ No_____

I. If no, please state the approximate number of times you applied paraquat without wearing any personal protective equipment.

_____

J. For each instance you wore personal protective equipment while applying paraquat, please identify which, if any, of the following you wore: (Check all that apply)

Personal Protective Equipment	Applicable?
1. Chemical-resistant or Waterproof Footwear and Socks	☐
2. Chemical-resistant Headgear for Overhead Exposure or Face Shield	☐
3. Dust/Mist Filtering or NIOSH/MSHA-Approved Pesticide Respirator	☐
4. Disposable Suit/Coveralls	☐
5. Long-sleeved Shirt	☐
6. Long Pants	☐
7. Protective Eyewear	☐
8. Rubber or Waterproof Apron	☐
9. Rubber or Waterproof Gloves	☐
10. Any Other Form of Personal Protective Equipment	☐

1. If you checked the box for "Any Other Form of Personal Protective Equipment" above, please describe the personal protective equipment used.

_____

K. Do you claim you were exposed to spray mist or drift from paraquat applied by another person?

Yes _____ No_____

If no, please move on to XIV.P.

L. For each time you were exposed to spray mist or drift from paraquat applied by another person, provide the following information to the best of your knowledge and recollection.

Approximate date			
Address of Home, Business, or Name of Farm/Ranch and City/State			
Did you work or live at location where product was applied? (Y/N)			
Basis for believing product applied was paraquat			
Years of exposure			
Person or entity applying product (if known)			
Relationship to person applying product, if any			
Application method			
Equipment used			
Crops and/or weeds to which product was applied			
Purpose			
Equipment used			
Nozzle type			
Application pressure			
Boom or application height			
Name(s) of paraquat products used during period			
Name(s) of product manufacturer (if known)			
Formulation[9]			
Strength or Concentration[10]			
Tank Mix[11]			

[9] For example, liquid formulation or granules.

[10] For example, 240 g/l or 360 g/l.

[11] Identify all components of the tank mixture containing paraquat, including but not limited to adjuvants, surfactants, spray modifiers, utility agents, or other pesticides.

Name of individual or entity that sold or provided paraquat product			
Did you purchase this paraquat product yourself? (Y/N)			
Do you possess records of purchase of paraquat product? (Y/N)			
Name of person or entity holding license to use Restricted Use Pesticides			
Issuing state for license			
License number			
Names and of others who witnessed spray mist or drift from application			

M. Did you wear any personal protective equipment during every instance you were exposed to paraquat by spray mist or drift?

Yes _____ No_____

N. If no, please state the approximate number of instances you were exposed to paraquat by spray mist or drift during which you did not wear any personal protective equipment.

_____

O. For each instance you were exposed to paraquat by spray mist or drift while wearing personal protective equipment, please identify which, if any, of the following you wore: (Check all that apply)

Personal Protective Equipment	Applicable?
1. Chemical-resistant or Waterproof Footwear and Socks	☐
2. Chemical-resistant Headgear for Overhead Exposure or Face Shield	☐
3. Dust/Mist Filtering or NIOSH/MSHA-Approved Pesticide Respirator	☐
4. Disposable Suit/Coveralls	☐
5. Long-sleeved Shirt	☐
6. Long Pants	☐
7. Protective Eyewear	☐
8. Rubber or Waterproof Apron	☐
9. Rubber or Waterproof Gloves	☐
10. Any Other Form of Personal Protective Equipment	☐

1. If you checked the box for "Any Other Form of Personal Protective Equipment" above, please describe the personal protective equipment used.

_____

P. To the best of your recollection and knowledge, did you ever enter or reenter fields within 48 hours of paraquat being sprayed in those fields?

Yes _____ No_____

If no, please move on to XIV.Y.

Q. If yes, approximately how many times has this occurred (*i.e.*, "entry or reentry occurrences")?

_____

R. Of those entry or reentry occurrences, approximately how many times did you enter or reenter those fields within 24 hours of paraquat being sprayed in those fields?

_____

S. Of those entry or reentry occurrences, approximately how many times did you enter or reenter those fields within 12 hours of paraquat being sprayed in those fields?

_____

T. For each entry or reentry occurrence, explain generally the purpose of that entry or reentry.

_____

U. For each entry or reentry occurrence, provide the following information.

Year	City/State	Frequency of Entry or Reentry	Estimated Duration of Entry or Reentry	Application Method & Duration	Crops and Weeds	Applicator Names and Applicator Nos.[12]	Names of Others Who Witnessed Reentry

V. Did you wear any personal protective equipment during each and every entry and reentry occurrence?

Yes _____ No_____

W. If no, please state the approximate number of entry or reentry occurrences during which you did not wear any personal protective equipment.

_____

[12] Please list the names of all individuals who applied the paraquat and their certification numbers.

X. For each entry and reentry occurrence where you wore personal protective equipment, please identify which, if any, of the following you wore: (Check all that apply)

Personal Protective Equipment	Applicable?
1. Chemical-resistant or Waterproof Footwear and Socks	☐
2. Chemical-resistant Headgear for Overhead Exposure or Face Shield	☐
3. Dust/Mist Filtering or NIOSH/MSHA-Approved Pesticide Respirator	☐
4. Disposable Suit/Coveralls	☐
5. Long-sleeved Shirt	☐
6. Long Pants	☐
7. Protective Eyewear	☐
8. Rubber or Waterproof Apron	☐
9. Rubber or Waterproof Gloves	☐
10. Any Other Form of Personal Protective Equipment	☐

1. If you checked the box for "Any Other Form of Personal Protective Equipment" above, please describe the personal protective equipment used.

_____

Y. Do you claim that you were exposed to paraquat on any other occasions or through any means not described or accounted for above?

Yes _____ No_____

If no, please move on to XV.

Z. If yes, please provide the following information for those instances of exposure to the best of your knowledge and recollection.

Date (s)	City/ State	Duration of exposure (Month/ Year)	Type of exposure (e.g. dermal, inhalation, etc.)	Brief description of manner in which you were exposed to paraquat	Name(s) of others who witnessed your exposure

AA. For every instance in which you claim that you were exposed to paraquat on other occasions or through means described in this section, did you wear any personal protective equipment?

Yes _____ No_____

BB. If no, please state the approximate number of occurrences during which you did not wear any personal protective equipment.

_____

CC. For each occurrence where you wore personal protective equipment, please identify which, if any, of the following you wore: (Check all that apply)

Personal Protective Equipment	Applicable?
1. Chemical-resistant or Waterproof Footwear and Socks	☐
2. Chemical-resistant Headgear for Overhead Exposure or Face Shield	☐
3. Dust/Mist Filtering or NIOSH/MSHA-Approved Pesticide Respirator	☐
4. Disposable Suit/Coveralls	☐
5. Long-sleeved Shirt	☐
6. Long Pants	☐
7. Protective Eyewear	☐
8. Rubber or Waterproof Apron	☐
9. Rubber or Waterproof Gloves	☐
10. Any Other Form of Personal Protective Equipment	☐

1. If you checked the box for "Any Other Form of Personal Protective Equipment" above, please describe the personal protective equipment used.

_____

XV. ACUTE PARAQUAT EXPOSURE

A. Do you claim that you swallowed paraquat or that paraquat got in your mouth?

Yes _____ No_____

B. If yes, please identify the approximate month(s)/year(s) when this happened, describe the circumstances, and indicate whether you took an adsorbent (e.g., activated charcoal, bentonite, Fuller's Earth).

_____

C. Do you claim that you got paraquat in your eyes?

Yes _____ No_____

D. If yes, please identify the approximate month(s)/year(s) when this happened, describe the circumstances, indicate whether you rinsed your eyes with clean water, and for how long you rinsed your eyes with clean water.

_____

E. Do you claim you got paraquat directly on your skin?

Yes _____ No_____

F. If yes, please identify the approximate month(s)/year(s) when this happened, describe the circumstances, indicate whether you immediately washed the affected area with soap and water, and for how long you washed the affected area with soap and water.

_____

G. Do you claim you got paraquat on your clothing?

Yes _____ No _____

H. If yes, please identify the approximate month(s)/year(s)) when this happened, describe the circumstances, and indicate whether you immediately removed the contaminated clothing and washed the affected area with soap and water. -

_____

I. Have you ever been treated for paraquat poisoning?

Yes _____ No_____

J. If yes, identify the provider of that treatment, the month(s)/date(s) of such treatment, and a description of such treatment.

_____

XVI. SYMPTOMS WITHIN 24 HOURS OF PARAQUAT EXPOSURE

A. Did you experience any symptoms within 24-hours after mixing, loading, applying, or being exposed to paraquat? Yes _____ No ____

B. If yes, identify any symptoms you experienced within 24-hours that you claim were caused by exposure to paraquat.

_____

XVII. USE OF OTHER INDUSTRIAL/AGRICULTURAL CHEMICALS

A. To the best of your knowledge and recollection, identify all the following industrial or Agricultural Chemicals you have ever used, handled, applied, disposed of, or were otherwise exposed to at any time in your life. Check all that apply.

Industrial/Agricultural Chemicals	Applicable?
1. 2,4-D (*i.e.*, Crossbow, Curtail, Weedar, Weedone)	☐
2. 2, 4, 5, -T (*i.e.*, Agent Orange, Esteron, Trinoxol)	☐

Industrial/Agricultural Chemicals	Applicable?
3. Acephate (*i.e.*, Bonide, Martin's Surrender, Orthene)	☐
4. Acetochlor (*i.e.*, Harness, Keystone, SureStart, Surpass, Volley, Warrant)	☐
5. Alachlor (*i.e.*, Lasso)	☐
6. Aldrin (*i.e.*, Octalene)	☐
7. Arsenic/Arsenate	☐
8. Atrazine	☐
9. Bidrin	☐
10. Boric Acid	☐
11. Calcium Arsenate	☐
12. Carbaryl (Sevin)	☐
13. Chlordane	☐
14. Chloropicrin (*i.e.*, Chlor-O-Pic, Metapicrin, Timberfume, Tri-Clor)	☐
15. Chlorothalonil (*i.e.*, Bravo, Daconil 2787, Echo, Exotherm Termil, Nopcocide, Repluse, Tuffcide)	☐
16. Chlorpyrifos (*i.e.*, Dursban, Lorsban)	☐
17. Copper Hydroxide (*i.e.*, Champ, Kocide, NuCop)	☐
18. Crop Oil	☐
19. Cyanazine (Bladex)	☐
20. DDT	☐
21. DEET	☐
22. Diazinon	☐
23. Dicamba (*i.e.*, Banvel, Clarity, Sterling Blue)	☐
24. Dichloropropene (*i.e.*, Telone)	☐
25. Dieldrin	☐
26. Dimite	☐
27. Dinoseb/ Dinitro (*i.e.*, Preemerge, Sinox PE, Dow General)	☐
28. Diquat	☐

Industrial/Agricultural Chemicals	Applicable?
29. Diuron (Karmex)	☐
30. Ethephon (*i.e.*, Arvest, Bromeflor)	☐
31. Glufosinate (*i.e.*, Cheetah, Rely 280)	☐
32. Glyphosate (*i.e.*, RoundUp)	☐
33. Hexachlorocyclohexane and/or beta-hexachlorocyclohexane	☐
34. Imazapyr (*i.e.*, Arsenal, Contain, Habitat)	☐
35. Insecticides (*i.e.*, Orthene, Payload, Malathion, Guthion, Phosdrin, Dursban, Lorsban, Counter, Dylox, Penncap, Phoskil, Imidan, Trithion, Folidol, dibrom/Naled)	☐
36. Lindane	☐
37. Linuron (*i.e.*, Londax, Lorox)	☐
38. Maneb, Mancozeb (*i.e.*, Agsco, Cover-up, Dithane, Fortuna, Granol, Koverall, Lesco, Manzate, Penncozeb, Roper)	☐
39. Methoxychlor	☐
40. Methyl Bromide (*i.e.*, Brom-o-Gas, Profume, Zytox)	☐
41. Metolachlor (*i.e.*, Acuron, Brawl, Dual II Magnum, Matador, Prefix, Sequence)	☐
42. Napthalene	☐
43. Nicotine	☐
44. Parathion	☐
45. Pendimethalin (*i.e.*, Acumen, Framework, Stealth)	☐
46. Pentachlorophenol	☐
47. Permethrin	☐
48. Phosphorus Paste	☐
49. Potassium cyanate	☐
50. Propanil (*i.e.*, Stampede)	☐
51. Propazine	☐
52. Pyrethrin	☐

Industrial/Agricultural Chemicals	Applicable?
53. Randox	☐
54. Ronnel	☐
55. Rotenone	☐
56. Simazine (*i.e.*, Princep)	☐
57. Sodium Flouride	☐
58. Strychnine	☐
59. Thallium Sulfate	☐
60. Triclopyr (*i.e.*, Crossbow)	☐
61. Trifluralin (*i.e.*, Treflan, Trust, Trilin)	☐
62. Any Other Industrial or Agricultural Chemicals	☐

1. If you checked box 62 for "Any other industrial or Agricultural Chemicals" above, please identify the industrial or Agricultural Chemical referenced.

_____

B. Provide the following information with respect to the other industrial or Agricultural Chemicals that were identified in Section XVI.A above (*i.e.*, questions 1-62 in the above chart) which you used, handled, applied, disposed of, or were exposed to.

Product and manufacturer name	**Approximate years of use**	**Frequency**	**Quantity Used**	**Method of use**	**How you obtained the product**	**The individual or entity from whom you obtained the product**	**Names & Location[13] of Others Present**

[13] The term "location" here refers to the approximate distance between the person(s) present and the applicator.

C. Did you wear any personal protective equipment during every instance you used each of the other industrial or Agricultural Chemicals identified above?

Yes _____ No_____

D. If no, please state the approximate number of instances you used any of the other industry or Agricultural Chemical products described above during which you did not wear personal protective equipment.

_____

E. For each instance you used any of the other industry or Agricultural Chemicals described above while wearing personal protective equipment, please identify which, if any, of the following you wore: (Check all that apply)

Personal Protective Equipment	**Applicable?**	**With Which (or all) Chemicals Identified Above?**
1. Dust/Mist Filtering or NIOSH/MSHA-Approved Pesticide Respirator	☐	
2. Rubber or Waterproof Gloves	☐	
3. Chemical-resistant or Waterproof Footwear and Socks	☐	
4. Chemical-resistant Headgear for Overhead Exposure or Face Shield	☐	
5. Disposable Suit/Coveralls	☐	
6. Long-sleeved Shirt	☐	
7. Long Pants	☐	
8. Protective Eyewear	☐	
9. Rubber or Waterproof Apron	☐	
10. Any Other Form of Personal Protective Equipment (Identify_____)	☐	

F. Have you ever been employed as an occupational welder or welded for more than 50% of your work day?

Yes _____ No_____

G. If yes, identify the date ranges during which you engaged in welding and for each date range, please provide the following information

Range of Exposure (Years)	Location (City/State)	Frequency	Purpose	Did welding take place in confined space? (Y/N)	Type of welding (i.e. SMAW, GMAW, etc.)	Type of metal involved	Type of equipment used

H. Identify all the following substances that you have been exposed to. (Check all that apply)

Substance	Applicable?	Substance Type	Range of Exposure (Years)	Details of Exposure including Circumstances, Duration and Frequency of Exposure
1. Heavy metals (*e.g.*, iron, mercury, manganese)	☐			
2. Polychlorinated Biphenyls (PCBs)	☐			
3. Solvents (*e.g.*, hydrocarbon solvents like paint thinners, paint removers, cleaning fluids, trichloroethylene (TCE), organic solvents like acetone)	☐			
4. Wood Preservatives	☐			

XVIII. MISCELLANEOUS MEDICAL INFORMATION

A. Identify all medical conditions that you have been diagnosed with or have been medically treated for. (Check all that apply)

Condition	Applicable?	Month/Year of Diagnosis	Any Medical Treatment?	Month/Year of Treatment	Hospital and/or Treatment Provider
1.	☐				
2. Hepatitis C	☐				
3. Hospitalization for CNS Infection	☐				
4. Hospitalization for Sepsis	☐				
5. Influenza Requiring Hospitalization	☐				
6. Irritable Bowel Syndrome (IBS)	☐				
7. Japanese Encephalitis	☐				
8. Lyme Disease	☐				
9. Measles	☐				
10. Strep Infection Requiring Hospitalization	☐				
11. West Nile virus	☐				

B. Have you ever suffered from any head injuries and/or concussions?

Yes _____ No_____

C. If yes, identify the date(s) of the head injury/concussion, the cause of the injury/concussion, and any symptoms experienced from the injury/concussion, and state whether you received medical treatment for that injury/concussion, what diagnosis (if any) made by a doctor following the injury/concussion, and the Health Care Provider of that medical treatment and/or diagnosis.

_____

D. Have you ever been diagnosed with pulmonary (lung) fibrosis?

Yes _____ No_____

E. If yes, identify the date of the diagnosis and the Health Care Provider who diagnosed you for pulmonary (lung) diagnosis:

_____

F. If you were diagnosed with pulmonary (lung) fibrosis, did you experience any of the following symptoms: (Check all that apply):

Symptom	Applicable?
1. Shortness of breath	☐
2. Dry, hacking cough	☐
3. Fast, shallow breathing	☐
4. Gradual unintended weight loss	☐
5. Fatigue	☐
6. Aching joints and muscles	☐
7. Clubbing (widening and rounding) of the tips of the fingers or toes	☐
8. Cyanosis (blueish skin in fair-skinned people or gray or white skin around the mouth or eyes in dark-skinned people)	☐

G. Have you ever used well water as a water source, whether in your home or elsewhere?

Yes _____ No_____

H. If yes, for each instance where well water was the water source, identify the approximate year(s) of use and the location of the well.

_____

I. Have you ever used methamphetamines? Yes _____ No ____

If yes, please provide month/year(s) of use: _____

J. Have you ever used any nicotine products? Yes _____ No _____

If yes, please identify which products, approximate months/years of usage and frequency of usage: _____

XVIX. KNOWLEDGE REGARDING LAWSUIT

A. Identify all individuals, entities, publications, or studies from which you obtained any information (whether oral or written) related to your allegation that Parkinson's disease is connected in any way to your use of paraquat or any other chemical, including but not limited to Agricultural Chemicals, that you may have used during your lifetime. Provide a description of the information you obtained. Your response should not include information provided to you by your attorneys but should include (1) any information you obtained prior to your retention of an attorney, (2) any solicitation letters/communications from any attorneys, and (3) any information you obtained independently from your attorneys or their agents.

_____

XX. WAGE LOSS

A. Have you been unable to work as a result of the injury(ies) you claim this lawsuit? Yes _____ No _____

B. If yes, please provide the following information:

Month(s)/Year(s) unable to work	Name of Employer	City/State of Employer	If known, approximate lost wage dollar amount

XXI. COMMUNICATIONS REGARDING LAWSUIT

C. When did you first contact your lawyer about this case? In providing a response, provide an approximate date without divulging attorney-client communication.

_____

XXII. DAMAGES

A. Based on what you know at this time, do you have any medical expenses or out-of-pocket expenses due to the injury(ies) you have suffered because of your paraquat exposure? Yes _____ No _____

If yes, please state the approximate amount of medical expenses or out-of-pocket expenses**:** _____

XXIII. RELEVANT PERSONS / WITNESSES

B. Identify any person who has firsthand personal knowledge regarding your paraquat exposure and/or injuries suffered because of your paraquat exposure. For each such person, identify:

1. Name. _____

2. Last known address. _____

3. Relationship to you, if any. _____

4. The case-related subject matter that may be within this person's knowledge, so far as is known to you.

_____

XXIV. COMMUNICATIONS WITH DEFENDANTS

A. Have you, or has anyone acting on your behalf, communicated with, interviewed, or obtained statements from any of the Defendants (i.e. Syngenta Crop Protection LLC, Syngenta AG, Chevron USA Inc., or any other Defendant named in your specific lawsuit) regarding allegations in the lawsuit? **This question excludes privileged communications exclusively between you and your counsel, and between your counsel and experts retained in this litigation.**

Yes _____ No_____

B. Have you, or has anyone acting on your behalf, communicated with, interviewed, or obtained statements from any person or any entity about Defendants' business with respect to paraquat, the health effects of paraquat, and/or the usage of and practices associated with paraquat, since the filing of this lawsuit? **This question excludes privileged communications exclusively between you and your counsel, and between your counsel and experts retained in this litigation.**

Yes _____ No_____

C. If the answer to either question above is yes, please provide the following information:

1. Which (1) Defendant or (2) other person or entity with whom the communication occurred?

2. the month/year of the communication or statement;

3. where (city/state) the communication or statement occurred;

4. who was present during the communication or statement;

5. the matters and things stated by the person in the communication or statement;

6. whether the communication or statement was oral or written and, if oral, whether the communication or statement was recorded and whether any notes or memoranda of the communication or statement were made; and

7. who has possession of any writing, recording, notes, or memoranda of the communication or statement.

XXV. BANKRUPTCY

A. Since you first were exposed to paraquat, have you filed for bankruptcy?

Yes _____ No_____

B. If yes, please provide the following information:

Date You Filed for Bankruptcy	Court Where Bankruptcy was Filed	Name of Your Bankruptcy Attorney, if any	Case Number	Name of Trustee	Date Bankruptcy was Closed/Finalized

XXVI. DOCUMENTS[14]

Please attach to this Fact Sheet the Documents described below that are in your possession, custody or control. For purposes of this Plaintiff's Fact Sheet, Plaintiff is not required to turn over any attorney-client privileged records or to obtain records from third party entities (such as insurance carriers or Health Care Providers):

A. Any and all Documents showing any type of medical care, services, and/or consultation you have received from any Health Care Providers identified above including but not limited to (1) all primary Health Care Providers identified in this form; (2) any neurologists identified in this form; (3) any Health Care Providers you have seen in relation to any brain or head injury identified in this form; (4) any Health Care Providers you have seen in relation to any chemical or toxic exposure identified in this form; and (5) all Health Care Providers you have seen since the onset of Parkinson's disease symptoms identified in this form.

B. All Documents related to any genetic testing you have undergone identified above, including any Documents reflecting the results of such testing.

C. Documents in your possession sufficient to prove your employment history, including Documents indicating business ownership.

D. All Documents related to any training, certification, or licensing that any person or entity, including you or any of your employers or supervisors, have received related to Agricultural Chemicals in any response to Section XVI of this form.

E. All Documents (including, without limitation, receipts, invoices, labeling, instructions, warnings, precautions, and marketing materials) relating to your purchase, use, handling, and/or disposal of Agricultural Chemicals, including but not limited to paraquat, and any other chemicals in any response to Section XIV or Section XVI of this form.

F. All other Documents related to the farming activities on each farm where you lived or worked, including planting and harvesting records or other land-use records, pesticide application records, pest management records, photographs or videos of the farm, maps of the farm, and any records required to be retained by state or federal law, including records of federally restricted use pesticide applications.

G. All Documents and information relating to any industrial hygiene or other air, water, or medical monitoring for any exposure to paraquat or chemicals identified in your responses to Section XVI.

H. All Documents reflecting any worker's compensation claims since your first exposure to paraquat and identified in this form.

---

[14] For the purpose of this Fact Sheet, Document is defined as any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone-records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

I. Documents sufficient to show the acreage and crops for each farm you worked on or at, including but not limited to FSA-578 and 1026A Forms, USDA FSA Detailed Acreage History Report Forms, and all records from the Risk Management Agency of the USDA.

J. All Documents that you relied upon to learn about the relationship between Parkinson's disease and paraquat.

K. All Documents known to you at this time that relate to your claim for economic damages in this lawsuit.

L. All Documents, including public records, identifying, referring, or relating to surveillance, investigation, or other information gathering performed by or on behalf of Plaintiff relating to any of the Defendants in this action.

M. All investigative reports by you, including but not limited to financial and criminal background checks, concerning Defendants.

N. All Documents in your possession that refer or relate to Defendants in this action or Defendants' employees (current or former). This Request includes but is not limited to surveys, questionnaires, promotional materials, or other Documents or materials exchanged between you and Defendants.

O. Documents in your possession reflecting, depicting, or describing any piece of farm equipment or implement you used to apply paraquat at any time, including without limitation the tractor, tank, and sprayer (including nozzles). For row crops, this request includes the farm equipment or implement(s) used to prepare or to plant any crop planted on acreage treated with paraquat, including without limitation the planter, drill, any type of cultivator or harrow, and fertilizer application equipment. This request encompasses documents such as, without limitation, photographs, videos, equipment manuals or instructions, proof of purchase, warranties, and/or maintenance or repair records.

P. Inspection report created at the time of usage of any equipment or implement responsive to Request O (directly above) that remains in your possession.

Q. All Documents identified in your answers to any questions in this Fact Sheet and all Documents on which you relied on responding to any questions in this Fact Sheet.

XXVII. REMINDER FOR AUTHORIZATIONS

If not already provided, please complete, sign, and provide the following Authorizations, as applicable:

- Authorization for Release of Health Information (Attachment A). For this authorization, include an authorization for release of records for all Health Care Providers listed in this Fact Sheet, including those listed in Sections IX and XX.
- Authorization to Disclose Employment Information (Attachment B). For this authorization, include an authorization for release of records for all employers listed in Section III.
- Request Pertaining to Military Records (Attachment C).
- Social Security Administration Consent for Release of Information (Attachment D).
- Authorization to Disclose Workers' Compensation Records (Attachment E) (or other appropriate form).
- Authorization to Disclose Insurance Information (Attachment F).
- Authorization to Disclose Disability Information (Attachment G).
- Request Pertaining to Farm Service Agency Records (Attachment H).

XXVIII. VERIFICATION

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

I further declare that I have engaged in the best efforts to identify, locate, and supply all of the information and documents requested in this Plaintiff Fact Sheet. I acknowledge that I have an obligation to promptly supplement the above responses if I learn that they are in some material respect incomplete or incorrect.

I declare under penalty of perjury that the foregoing is true and correct.

_____
Name (please print)

_____
Signature

_____
Date Signed

EXHIBIT 3

Attachment A

Authorization to Disclose Your Protected Health Information

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

TO: _____
Patient Name: _____
DOB: _____
SSN: _____

I, _____ ("Individual"), authorize you ("Provider"), and your employees, agents, partners, and affiliates, to release and furnish to _____ copies of my protected health information as set forth below:

- All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology films, mammograms, myelograms, CT Scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills, and insurance records.
- All insurance records.
- All workers' compensation claims or records, including any report of injury, all treatment records, and evidence of any benefits received/paid.

1. To the above-named person's medical provider: this authorization is being forwarded by, or on behalf of, attorneys for the defendants. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition at a deposition or trial.

2. I understand that the information in the above-named person's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include

information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to the above-named person's insurance company when the law provides my insurer with the right to contest a claim under my policy. Otherwise, this authorization shall remain effective throughout the duration of the litigation and shall expire automatically at the close of the litigation.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of this health information, I can contact the releaser indicated above.

5. A notarized signature is <u>not</u> required. 45 CFR § 164.508. A copy of this authorization may be used in place of an original.

_____ _____

Signature of individual or personal representative Date

_____

Name of individual and, if applicable, personal representative

_____

Description of Personal Representative's authority to sign for individual
(attach documents that show authority)

Attachment B

HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR § 164.508 TO RELEASE EMPLOYMENT INFORMATION

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

TO: Name of Employer _____
Address, City, State, Zip Code _____
_____

RE: Employee Name_____ AKA_____
Date of Birth _____ Social Security Number_____
Address_____

I authorize the disclosure of my employment records including any medical information protected by HIPAA, 45 CFR § 164.508, for the purpose of review and evaluation in connection with a legal claim. I expressly request that all entities identified above disclose full and complete records including the following:

This will authorize you to furnish copies of all applications for employment; resumes; records of all positions held; job descriptions of positions held; wage and income statements and/or compensation records; wage increases and decreases; performance evaluations, reviews, and reports; transfers, statements, and comments of fellow employees; all documents relating to discipline including warnings, reprimands, suspensions, terminations, and all other forms of discipline; attendance records; W-2s; worker's compensation files; all medical records, x-rays, and test results; any physical examination records; all documents relating to my absences, illnesses, and injuries; any records pertaining to claims made relating to health, disability, or accidents in which I was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf; and any other records relating to my employment and/or in my personnel file.

Information about HIV/AIDS and alcohol/substance abuse may be disclosed.

I hereby authorize and request you to release the information to [ADDRESS] (the "Records Requester").

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned, or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requester at that time.

I acknowledge the right to revoke this authorization by sending a written revocation notice to the above-referenced address, but that this revocation notice will not apply to information already released in response to this authorization and will not affect any actions taken in reliance on this authorization prior to the date my written revocation is received. I understand that the entity to which this authorization is directed may not condition treatment, payment, enrollment, or

eligibility benefits on whether I sign the authorization. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records herein.

This authorization shall remain effective throughout the duration of the litigation and shall expire automatically at the close of the litigation.

_____ _____

Signature of employee or personal representative Date

_____

Name of employee and, if applicable, personal representative

_____

Description of Personal Representative's authority to sign for employee
(attach documents that show authority)

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

1. General Information. The Standard Form 180, Request Pertaining to Military Records (SF 180) is used to request information from military records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available". Include as much of the requested information as you can. Incomplete information may delay response time. To determine where to mail this request see Page 2 of the SF 180 for record locations and facility addresses. Medical information may be withheld from a patient if determined that the information would be detrimental to the patient's physical or mental health or would likely cause the patient to harm himself or someone else.

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

2. Personnel Records/Military Human Resource Records/Official Military Personnel File (OMPF) and Medical Records/Service Treatment Records (STR). Personnel records of military members who were discharged, retired, or died in service **LESS THAN 62 YEARS AGO** and medical records are in the legal custody of the military service department and are administered in accordance with rules issued by the Department of Defense and the Department of Homeland Security (DHS, Coast Guard). STRs of persons on active duty are generally kept at the local servicing clinic. After the last day of active duty, STRs should be requested from the appropriate address on page 2 of the SF 180 (See item 3, Archival Records, if the military member was discharged, retired or died in service more than 62 years ago).

a. Release of information: Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations, the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's authorized legal recipient has access to almost any information contained in that member's own record. The authorization signature of the service member or the member's authorized legal recipient is needed in Section III of the SF 180. Others requesting information from military personnel records and/or STRs must have the release authorization in Section III of the SF 180 signed by the member or authorized legal recipient. If the appropriate signature cannot be obtained, only limited types of information can be provided (DoD 6025.18-R C8). If the former member is deceased, the surviving next-of-kin (NOK) may be entitled to greater access to a deceased veteran's records than a member of the general public (DoD 6025.18-R C6.2.1.2). The NOK may be any of the following: unmarried/surviving spouse, father, mother, son, daughter, sister, or brother. Requesters **MUST provide proof of death, such as the DD Form 1300, Casualty Report, a copy of a death certificate, newspaper article (obituary) or death notice, coroner's report of death, funeral director's signed statement of death, or verdict of coroner's jury.**

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

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

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

b. Fees for Archival Records: Access to archival records are granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). If a fee applies to the copies of documents in the requested record, you will receive an invoice. Copies will be sent after payment is made. For more information see http://www.archives.gov/st-louis/archival-programs/military-personnel-archival/ompf-archival-requests.html.

4. Where reply may be sent. The reply may be sent to the service member or any other address designated by the service member or other authorized requester. If the designated address is NOT registered to the addressee by the U.S. Postal Service (USPS), provide BOTH the addressee's name AND "in care of" (c/o) the name of the person to whom the address is registered on the NAME line in Section III, item 3, on page 1 of the SF 180. The COMPLETE address must be provided, INCLUDING any apartment/suite/unit/lot/space/etc. number. NOTE: If requester desires to send his/her record to a third party, he/she must fill out a DD Form 2870 authorizing the releasing agency to release the record and the timeframe of the authorization. The form may be downloaded using most commercial web search tools by entering "DD Form 2870" as a search term.

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

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

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

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

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

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

Standard Form 180 (Rev. 4-2011 <Page>)
Prescribed by NARA (36 CFR 1233.18 (d))
Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 04/30/2024

REQUEST PERTAINING TO MILITARY RECORDS

Requests can be submitted online using eVetRecs at http://www.archives.gov/veterans/military-service-records/

To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

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

1. NAME USED DURING SERVICE (last, first, full middle)	2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH

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

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

6. PLEASE LIST LAST FOUR DUTY STATIONS, IF KNOWN: 1. _____ 2. _____ 3. _____ 4. _____

7. IS THIS PERSON DECEASED? ☐ NO ☐ YES - ***MUST** provide Date of Death if veteran is deceased:* _____

8. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☐ **DD Form 214 or equivalent:** Year(s) in which form(s) issued to veteran (Date of Separation):_____
This form contains information used to verify military service. **An UNDELETED DD Form 214 is ordinarily required to determine eligibility for benefits**. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost. Please note – recent veterans may be able to request a DD Form 214 through milConnect by visiting: https://www.va.gov/records/get-military-service-records/
An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a **DELETED** copy.

☐ **Official Military Personnel File (OMPF):** The OMPF may include duty stations and assignments, training and qualifications, awards and decorations received, disciplinary actions, administrative remarks, enlistment and/or discharge information (including DD Form 214, Report of Separation, or equivalent), and other personnel actions. Detailed information about the veteran's participation in battles and their military engagements is NOT contained in the record.

☐ **Medical Records:** Includes health (outpatient), extended ambulatory, and dental records. If inpatient/hospitalization records are requested, please specify below.

☐ I request inpatient/hospitalization records from _____(facility), last treated in _____(year). **(NOTE: Fields are required)**
If available, you may receive copies of inpatient narrative summaries, operative reports, discharge summaries, etc. contained in the record.

☐ **Dental Records:** Please check this box if **ONLY** dental records are needed from the medical record.

☐ **Other (Please Specify):** _____

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

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☐ Other (explain)

Explain here: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER NAME: _____

2. RELATIONSHIP TO VETERAN: _____

3. ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section 1, above.
☐ I am the DECEASED VETERAN'S NEXT-OF-KIN **(MUST submit Proof of Death.** See item 2a on instruction sheet.)

☐ I am the VETERAN'S LEGAL GUARDIAN **(MUST submit copy of Court Appointment)** or AUTHORIZED REPRESENTATIVE (MUST submit copy of Authorization Letter or Power of Attorney)
☐ OTHER (Specify): _____

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

Name

Street Address Apt. #

City State ZIP Code

Daytime Phone Fax Number

Email Address

5. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section 3 is true and correct and that I authorize the release of the requested information. *(See items 2a or 3a on the accompanying instructions sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request is for archival records.)*

Signature Required – Do not print **Date**

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

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

BRANCH	CURRENT STATUS OF SERVICE MEMBER	Personnel Record	Medical or Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired 10/1/2004 – 12/31/2013	1	11
	Discharged, deceased, or retired on or after 1/1/2014	1	13
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, IRR, Retired Reserve in non-pay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	2	13
COAST GUARD	Discharged, deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired 4/1/1998 – 9/30/2006	14	11
	Discharged, deceased, or retired 10/1/2006 – 9/30/2013	3	11
	Discharged, deceased, or retired on or after 10/1/2013	3	14
	Active, Reserve, Individual Ready Reserve or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1895	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired 1/1/1999 - 12/31/2013	4	11
	Discharged, deceased, or retired on or after 1/1/2014	4	8
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	
	Discharged, deceased, or retired 10/16/1992 – 9/30/2002	14	11
	Discharged, deceased, or retired (including TDRL) 10/1/2002 – 12/31/2013	7	11
	Discharged, deceased, or retired (including TDRL) on or after 1/1/2014	7	9
	Current Soldier (Active, Reserve (including Individual Ready Reserve) or National Guard)	7	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired 1/1/1995 – 12/31/2013	10	11
	Discharged, deceased, or retired on or after 1/1/2014	10	8
	Active, Reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS and SELF-SERVICE WEBSITES (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1	**Air Force Personnel Center AFPC/DP2SSM 550 C Street West JBSA-Randolph TX 78150-4721 Fax: 210-565-3124 Email: DP2SSM.MILRECS.INCOMING@US.AF.MIL**	**6**	**National Archives & Records Administration Research Services (RDT1R) 700 Pennsylvania Avenue NW Washington, DC 20408-0001**	**11**	**Department of Veterans Affairs ATTN: Release of Information Claims Intake Center P.O. Box 4444 Janesville, WI 53547-4444 Fax: 844-531-7818 https://www.va.gov**
2	**Air Reserve Personnel Center Total Force Service Center: 1-800-525-0102 https://mypers.af.mil/**	**7**	**US Army Human Resources Command's web page: *https://www.hrc.army.mil/content/1113* or 1-888-ARMYHRC (1-888-276-9472)**	**12**	**Division of Commissioned Corps Officer Support ATTN: Records Officer 1101 Wooton Parkway, Plaza Level, Suite 100 Rockville, MD 20852**
3	**Commander, Personnel Service Center (BOPS-C-MR) MS7200 US Coast Guard 2703 Martin Luther King Jr Ave SE Washington, DC 20593-7200 https://www.dcms.uscg.mil/ompf**	**8**	**Navy Medicine Records Activity (NMRA) BUMED Detachment St. Louis 4300 Goodfellow Boulevard, Building 103 St. Louis, MO 63120 Fax number: 314-260-8128**	**13**	**AF STR Processing Center ATTN: Release of Information 3370 Nacogdoches Road, Suite 116 San Antonio, TX 78217**
4	**Headquarters U.S. Marine Corps Manpower Management Records & Performance (MMRP-10) 2008 Elliot Road Quantico, VA 22134-5030 SMB.MANPOWER.MMRP-10@usmc.mil**	**9**	**AMEDD Army Record Processing Center 3370 Nacogdoches Road, Suite 116 San Antonio, TX 78217 Fax Number: 210-201-8310**	**14**	**National Personnel Records Center (Military Personnel Records) 1 Archives Drive St. Louis, MO 63138-1002 *http://www.archives.gov/veterans/military-service-records/***
5	**Marine Corps Forces Reserve 2000 Opelousas Avenue New Orleans, LA 70114**	**10**	**Navy Personnel Command (PERS-313) 5720 Integrity Drive Millington, TN 38055-3130**		

EXHIBIT 4

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

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

NOTE: Do not use this form to:

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

How to Complete this Form

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

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

PRIVACY ACT STATEMENT

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

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

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

PAPERWORK REDUCTION ACT STATEMENT

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

Social Security Administration

Form Approved
OMB No. 0960-0566

Consent for Release of Information

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

TO: Social Security Administration

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

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

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

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

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

Check at least one box. We will not disclose records unless you include date ranges where applicable.

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

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

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

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

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

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

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

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

Attachment E

AUTHORIZATION FOR RELEASE OF WORKER'S COMPENSATION RECORDS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

TO: Name _____
Address, City, State, Zip Code _____
_____

This will authorize you to furnish copies of any and all workers' compensation records of any sort, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____
Name of Claimant

Whose date of birth is _____ and whose social security number is _____.

I hereby authorize and request you to release the information to [ADDRESS] (the "Records Requester").

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned, or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requester at that time.

I acknowledge the right to revoke this Authorization to Release Employment Information by sending a written revocation notice to the above-referenced address, but that this revocation notice will not apply to information already released in response to this authorization and will not affect any actions taken in reliance on this authorization prior to the date my written revocation is received. I understand that the entity to which this authorization is directed may not condition treatment, payment, enrollment, or eligibility benefits on whether I sign the authorization. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records herein.

This Authorization to Release Employment Information shall remain effective throughout the duration of the above-referenced litigation and shall expire automatically at the close of the litigation.

_____ _____
Signature of claimant or personal representative Date

_____
Name of claimant and, if applicable, personal representative

_____
Description of Personal Representative's authority to sign for claimant
(attach documents that show authority)

Attachment F-1

AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

TO: Name _____
Address, City, State, Zip Code _____
_____

RE: Insured Name _____
Date of Birth _____ Social Security Number _____

I authorize you to furnish copies of any and all documents relating to any insurance policy or policies under which the above-referenced insured were covered and claimed benefits, including, but not limited to, claims made and payments received for such claims, as well as applications, forms, and correspondence or communications of any kind between you and the insured. I further authorize you to furnish copies of all medical, health, hospital, physicians, nursing, or allied health professional reports, records, notes, or invoices or bills in your possession related to the insured.

You are authorized to release the above records to: [INSERT ADDRESS] (the "Records Requester"), who has agreed to pay reasonable charges made by you to supply copies of such records.

This authorization does not authorize you to disclose anything other than documents and records to anyone.

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned, or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requester at that time. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records described herein.

This authorization shall remain effective throughout the duration of the litigation and shall expire automatically at the close of the litigation.

_____ _____
Signature of claimant or personal representative Date

_____
Name of claimant and, if applicable, personal representative

_____
Description of Personal Representative's authority to sign for claimant
(attach documents that show authority)

_____ _____
Signature of witness Date

Attachment F-2

AUTHORIZATION FOR RELEASE OF CROP INSURANCE RECORDS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

Requester: _____
(Grower's Name)

Requester's Current Address: _____

_____

Date of Birth: _____

Social Security Number: _____

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. § 1001 by a fine of not more than $10,000.00 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. § 552(a)(i)(3) by a fine of not more than $5,000.00.

I request that the following records be released:

> Full and complete copies of all insurance policies, claims submitted, and any maps, plat books and descriptions of land or property related to any insurance coverage provided to [Farmer Name] and/or [Farming Entity Name], individually, jointly and/or by and through one or more partnerships, corporations or other entities, by the United States Department of Agriculture, Farm and Foreign Agriculture Services, Farm Service Agency, the Risk Management Agency and/or any private entity, from January 1, 1964 through the present, inclusive.

Pursuant to 7 U.S.C. § 1502(c)(2)(B), I further request, authorize and direct you to release any and all information relating to [Farmer Name] and/or [Farming Entity Name], including the foregoing records, to [ADDRESS].

I am voluntarily signing this consent, without promises being made to me, or any entity that I represent, nor under threat of duress or coercion.

NAME: _____

SIGNATURE: _____ (Signature of Grower/Requester)

DATE AND TIME: _____

Attachment G

AUTHORIZATION FOR RELEASE OF DISABILITY CLAIMS RECORDS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

TO: Name _____
Address, City, State, Zip Code _____
_____

RE: Claimant Name _____
Date of Birth _____ Social Security Number _____

I authorize you to furnish copies of any and all records of disability claims of any sort, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning the above-referenced claimant.

You are authorized to release the above records to: [ADDRESS] (the "Records Requester"), who has agreed to pay reasonable charges made by you to supply copies of such records.

This authorization does not authorize you to disclose anything other than documents and records to anyone.

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned, or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requester at that time. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records described herein.

This authorization shall remain effective throughout the duration of the litigation and shall expire automatically at the close of the litigation.

_____ _____
Signature of claimant or personal representative Date

_____
Name of claimant and, if applicable, personal representative

_____
Description of Personal Representative's authority to sign for claimant
(attach documents that show authority)

_____ _____
Signature of witness Date

Attachment H

AUTHORIZATION FOR RELEASE OF FSA DOCUMENTS

AUTHORIZED IN CONNECTION WITH
In re Paraquat Prods. Liab. Litig.
Southern District of Illinois
No. 3:21-md-3004-NJR

RE: Requester: _____
Doing Business As (Grower's Name): _____
Requester's Current Address: _____
Date of Birth _____ Social Security Number_____

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. § 1001 by a fine of not more than $10,000.00 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. § 552a(i)(3) by a fine of not more than $5,000.00.

A. *Record Release:* I request that the following records be released:

1. All FSA records (including FSA 578, 1026A (if applicable), the USDA FSA Detailed Acreage History Report Form and aerial maps) and all records from the Risk Management Agency of the USDA relating to the above-named requester or any entity by or through which he or she may farm for the years **1964 through the present**.

Pursuant to 5 U.S.C. § 552a(b), I further request, authorize the release of any and all information relating to me, including the foregoing records, to: [INSERT ADDRESS] (the "Records Requester"), who has agreed to pay reasonable charges made by you to supply copies of such records.

I am voluntarily signing this consent, without promises being made to me, or any entity that I represent, nor under threat of duress or coercion.

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned, or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requester at that time. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records described herein.

This authorization shall remain effective throughout the duration of the litigation and shall expire automatically at the close of the litigation.

[Signature Page to Follow]

Signature of Grower/Requester | Date

Name of Grower/Requester

Description of Requester's authority to sign for Grower
(attach documents that show authority)

Signature of witness | Date