

PRESENT:

Honorable Helen E. Freedman, J.S.C.

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF NEW YORK

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: IN RE: NEW YORK RENU WITH MOISTURELOC :  
: PRODUCT LIABILITY LITIGATION :  
: :  
: :  
: :  
----- X

Index No. 766,000/2007

**CASE MANAGEMENT  
ORDER NO. 8**

----- X  
: THIS DOCUMENT APPLIES TO ALL CASES :  
: :  
----- X

**PLAINTIFF FACT SHEET**

Please provide the following information for each individual on whose behalf a claim is being made. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who used ReNu® with MoistureLoc®. Whether you are completing this fact sheet for yourself or for someone else, please assume that "You" means the ReNu® with MoistureLoc® user. In filling out this form, please use the following definitions: "healthcare provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, or entities involved in the diagnosis, care and/or treatment of you. Each plaintiff shall respond to this Fact Sheet as though it were standard discovery, providing responses in accordance with CPLR 3133.

If additional space is needed for any response, please attach additional sheets as necessary. If the person completing this Fact Sheet does not know or does not recall the information requested in any question(s), that response should be entered in the appropriate location(s).

Name of plaintiff: \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_

**I. CASE INFORMATION**

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

\_\_\_\_\_  
Name

\_\_\_\_\_  
Firm

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
Telephone number

\_\_\_\_\_  
Fax number

\_\_\_\_\_  
Email address

B. If you are completing this Fact Sheet in a representative capacity (*e.g.*, on behalf of the estate of a deceased person), please complete the following:

- 1 Your Full Name \_\_\_\_\_
- 2 Street Address \_\_\_\_\_
- 3 City, State and Zip Code \_\_\_\_\_
- 4 In what capacity are you representing the individual? \_\_\_\_\_
- 5 Your relationship to the represented person: \_\_\_\_\_

## II. PERSONAL INFORMATION

A. Please state your full name, sex, social security number, and date and place of birth:

\_\_\_\_\_  
Last Name                      First Name                      Middle Initial Sr./Jr.

Sex: Male \_\_\_ Female \_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Place of Birth: \_\_\_\_\_

B. Maiden or other names used by you or by which you have been known and dates when used: \_\_\_\_\_

C. Present Street Address: \_\_\_\_\_

\_\_\_\_\_

City	State	Zip Code
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D. Are you currently married? Yes \_\_\_ No \_\_\_

If "Yes," spouse's name: \_\_\_\_\_

Is your current spouse making a loss of consortium claim?

Yes \_\_\_ No \_\_\_

If a former spouse is making a loss of consortium claim, state his or her name and address:

\_\_\_\_\_

E. To your knowledge, has anyone in your immediate family or household been diagnosed with or suffered from any eye infection since January 1, 2001?

Yes \_\_\_ No \_\_\_ Do Not Know \_\_\_\_\_

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

- 1 Name: \_\_\_\_\_
- 2 Relation to You: \_\_\_\_\_
- 3 Description of Medical Condition: \_\_\_\_\_
- 4 Age at Onset of Condition: \_\_\_\_\_
- 5 Current Age (or Age at Death): \_\_\_\_\_

### III. CLAIM-RELATED INFORMATION

A. Are you claiming that you have suffered bodily injury as a result of exposure to ReNu® with MoistureLoc®?

Yes \_\_\_ No \_\_\_

B. Are you claiming mental and/or emotional damages as a result of exposure to ReNu® with MoistureLoc®?

Yes \_\_\_ No \_\_\_

C. Claim Information

1 When did you wear contact lenses:

From \_\_\_\_\_ (Month/Year) to \_\_\_\_\_ (Month/Year).

2 How frequently did you wear contact lenses during this time? \_\_\_\_\_

3 State the type and brand of contact lenses you used at the time of your alleged injury. (e.g., daily wear): \_\_\_\_\_

4 When did you use ReNu® with MoistureLoc®?

From \_\_\_\_\_ (Month/Year) to \_\_\_\_\_ (Month/Year).

5. In the last 5 years, has any optometrist, ophthalmologist, or other eye care professional advised you to discontinue contact lens use?

Yes \_\_\_ No \_\_\_

6. If "Yes" to III.C.5, identify the eye care professional who so advised you, and the date of the advice:

\_\_\_\_\_

7. Identify each disease, illness, medical injury, or any other type of injury that you claim to have suffered as a result of your alleged use of ReNu® with MoistureLoc®:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. State the date of onset of the symptoms of any disease, illness, or injury identified in your response to question III.C.7 above: \_\_\_\_\_

9. Are you making a claim for medical expenses as a result of the alleged injury identified in question III.C.7? "Medical Expenses" includes, but is not limited to, all charges for care, treatment or diagnosis by a medical professional; hospital costs, charges and expenses; and all medication expenses.

Yes \_\_\_ No \_\_\_ If Yes, state in what amount: \_\_\_\_\_

10. Do you have health insurance?

Yes \_\_\_ No \_\_\_

If Yes, Insurer \_\_\_\_\_ Policy # \_\_\_\_\_

If "No" to question III.C.10 above, are you covered by Medicare?

Yes \_\_\_ No \_\_\_

11. Are you making a claim for out-of-pocket expenses?

Yes \_\_\_ No \_\_\_

If Yes, state in what amount: \_\_\_\_\_

12. Are you making a claim for lost earnings or have you suffered an impairment of your ability to earn as a result of any condition which you believe was caused by your exposure to ReNu® with MoistureLoc®?

Yes \_\_\_ No \_\_\_

13. If "Yes," state the total amount of time which you have lost from work as a result of any and all condition(s) which you claim was caused by your exposure to ReNu® with MoistureLoc® and your understanding of the amount of income that you lost:

14. If you are making a claim for lost earnings and/or lost earning capacity, state your income from employment for each of the last five (5) years:

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

15. If you are making a claim for lost earnings and/or lost earning capacity, state whether you are currently employed.

Yes \_\_\_ No \_\_\_

If you are making a claim for lost earnings and/or lost earning capacity, please provide the following information for each and every employer you have had for the past ten (10) years:

Employer	Address	Dates of Employment	Job Description

16. If not employed, check all that apply and provide applicable dates:

a) Unemployed: (seeking work) Yes \_\_\_ No \_\_\_ Date \_\_\_\_\_

b) Unemployed: (not seeking work) Yes \_\_\_ No \_\_\_ Date \_\_\_\_\_

c) Retired Yes \_\_\_\_\_ No \_\_\_ Date \_\_\_\_\_

17. If you are currently disabled, please state the cause of your disability and the period of your disability. \_\_\_\_\_

**IV. CONTACT LENS SOLUTION**

A. During the time period when you used ReNu® with MoistureLoc®, did you use any other contact lens cleaning solution?

Yes \_\_\_ No \_\_\_

1. If yes, what other contact lens cleaning solution(s) did you use? \_\_\_\_\_

2. If yes, when did you use other contact lens cleaning solution(s)? \_\_\_\_\_

B. Please provide the information below for any contact lens cleaning solution product that you have used other than ReNu® with MoistureLoc® since January 1, 2001.

Non- ReNu® with MoistureLoc® Product	Period(s) of Use

C. During the time period when you used ReNu® with MoistureLoc®, where did you purchase or obtain the product?

\_\_\_\_\_

\_\_\_\_\_

1. What lot numbers are on the ReNu® with MoistureLoc® bottle that you used at the time you claim to have been injured? \_\_\_\_\_

2. What size bottle of ReNu® with MoistureLoc® were you using at the time you claim to have been injured?

\_\_\_\_\_

3. During the time period when you used ReNu® with MoistureLoc®, identify the name and address of the person/business that provided your contact lenses?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. In last five (5) years, have you used artificial tears, eye drops or eye lubricants? If yes, please identify the product(s) and when the product(s) was used?

\_\_\_\_\_  
\_\_\_\_\_

**V. MEDICAL DIAGNOSIS**

A. Please identify the diagnosing and treating medical professional(s) for each disease, illness or injury that you claim you suffered as a result of your alleged exposure to ReNu® with MoistureLoc® and the date of the diagnosis. Please provide a medical record authorization for each medical professional identified.

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Treatment received: \_\_\_\_\_  
Dates of treatment: \_\_\_\_\_

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Treatment received: \_\_\_\_\_  
Dates of treatment: \_\_\_\_\_

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Treatment received: \_\_\_\_\_  
Dates of treatment: \_\_\_\_\_

- B. Describe any physical symptoms, psychological symptoms or emotional problems that you allege to have experienced in connection with each disease, illness, or other medical injury you are seeking relief for in this case:

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If you are alleging psychological symptoms or emotional problems, please identify any physician that you have received psychological care and provide a medical records authorization.

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- C. Has any eye care professional told you that your injury was related to ReNu® with MoistureLoc®? If yes, please provide the name and address of the eye care professional.

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- D. Have you had a corneal scraping? If yes, please identify the date of the procedure, the physician who performed the procedure and provide the results of any culture.

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- E. Have you had a corneal transplant? If yes, please identify the date of the procedure, the physician who performed the procedure and where the procedure was performed.

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- F. Has any eye care professional recommended that you have a corneal transplant? If yes, please identify the eye care professional(s) making such a recommendation.

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G. What is your current best corrected visual acuity? (i.e. 20/20, 20/40, 20/80)

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H. What was your best corrected visual acuity at the time you started using MoistureLoc®? (i.e. 20/20, 20/40, 20/80)

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I. Are there persons (other than those already identified in this Fact Sheet) whom you believe are witnesses to your claimed injuries or damages? If yes, please provide their name(s) and address(es):

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_
- 5. \_\_\_\_\_

**VI. MEDICAL HISTORY**

A. Has any medical professional ever diagnosed you with any of the following:

Check yes or no; if "Yes" provide the date of diagnosis and medical professional or hospital information.

Disorder or Disease	Yes	No	Date(s) Diagnosed	Name and address of medical professional(s) and/or hospital(s) who diagnosed you
Conjunctivitis				
Fungal Keratitis				
Microbial Keratitis				
Bacterial Keratitis				
Glaucoma				
Cataracts				
Corneal Ulcer				

<b>Disorder or Disease</b>	<b>Yes</b>	<b>No</b>	<b>Date(s) Diagnosed</b>	<b>Name and address of medical professional(s) and/or hospital(s) who diagnosed you</b>
<b>Thygeson's Superficial Punctate Keratopathy</b>				
<b>Fuchs' Dystrophy</b>				
<b>Uveitis</b>				
<b>Retinal Detachment</b>				
<b>Retinoschisis</b>				
<b>Hypertensive Retinopathy</b>				
<b>Macular Degeneration</b>				
<b>Retinitis Pigmentosa</b>				
<b>Macular Edema</b>				
<b>Leber's Hereditary Optic Neuropathy</b>				
<b>Keratomycosis</b>				
<b>Ocular Surface Disease</b>				
<b>Immune System Disorder Including HIV<sup>1</sup></b>				
<b>Herpes Simplex Keratitis</b>				

<sup>1</sup> All information provided in this Fact Sheet with respect to HIV and herpes simplex keratitis is covered by the Confidentiality Order issued by the Court.

B. Have you ever been prescribed an immunosuppressant drug? (Immunosuppressant drugs include but are not limited to steroids, cyclosporine, and methotrexate)

Yes \_\_\_\_\_ No \_\_\_\_\_

If "Yes," please identify the drug and dates of use:

\_\_\_\_\_  
\_\_\_\_\_

C. Other than those individuals that you have identified above, please identify the name and address of any medical professional you have seen for eye care for any reason including but not limited to any ophthalmologist, optometrist, contact lens fitter, and/or primary care physician. Please provide a medical record authorization for each medical professional identified.

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

D. Identify the name and address of any other medical professional that has treated you since January 1, 1996. Please provide a medical record authorization for each medical professional identified.

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

Name: \_\_\_\_\_  
Specialty, if any: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

- E. Please provide the following information for each hospitalization that you have had during the last ten (10) years. Please provide a medical record authorization for each hospital identified. If you cannot remember all of the details, please list as much information as you can.

Name of hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for hospitalization: \_\_\_\_\_

Name of hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for hospitalization: \_\_\_\_\_

Name of hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for hospitalization: \_\_\_\_\_

Name of hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Reason for hospitalization: \_\_\_\_\_

**VII. PRIOR CLAIMS**

- A. Have you ever been convicted of, or pled guilty to, a felony and/or crime of fraud or dishonesty in the last ten (10) years?

Yes \_\_\_\_ No \_\_\_\_

- B. If "Yes" to VII.A, please identify the felony and the date of such conviction or plea.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Have you ever, at any time, filed a lawsuit or made a claim, other than in the present lawsuit, relating to your eyes or vision? Or have you filed a lawsuit or made a claim, other than in the present lawsuit, relating to any bodily injury, disease, illness, or other medical condition since January 1, 1996?

Yes \_\_\_\_ No \_\_\_\_

If "Yes" to either question in VII.C, please state:

1. The claims you made:

\_\_\_\_\_  
2. The name of the court in which each action was filed:

\_\_\_\_\_  
3. The docket or civil action number assigned to each such claim, action or suit:

\_\_\_\_\_  
4. The date on which the claim was filed:

\_\_\_\_\_  
5. The name and address of each medical professional who examined, treated, counseled or otherwise assisted you in connection with the claim:

\_\_\_\_\_  
6. The disposition of the claim, including the amount, date, and frequency of any award (if amount is per week, month, year, or other unit of time, provide duration, *e.g.* \$1,000/month for 24 months):

\_\_\_\_\_  
7. Did you testify either at trial or at a deposition? Yes \_\_\_\_ No \_\_\_\_

D. Have you ever filed a worker's compensation claim relating to your eyes or vision? Or have you filed a worker's compensation claim relating to any other bodily injury, disease, or illness since January 1, 1996?

Yes \_\_\_\_ No \_\_\_\_

If "Yes" to either question in VII.D, please provide the following for each claim:

1. Are you currently receiving worker's compensation benefits?

Yes \_\_\_\_\_ No \_\_\_\_\_

2. Date claim was filed:

\_\_\_\_\_

3. Name and address of the office where the claim was filed:

\_\_\_\_\_

\_\_\_\_\_

4. Claim/docket number, if applicable:

\_\_\_\_\_

5. Nature of disability claimed:

\_\_\_\_\_

6. Period of disability (please provide beginning and ending date – if ongoing or permanent, so state):

\_\_\_\_\_

7. Disposition of the claim, including the date, amount, and frequency of any award (if amount is per week, month, year, or other unit of time, provide duration, e.g. \$1,000/month for 24 months):

\_\_\_\_\_

8. Name and address of each medical professional who examined, treated, counseled or otherwise assisted you in connection with the claim:

\_\_\_\_\_

\_\_\_\_\_

E. Have you ever filed a disability claim with the Social Security Administration or the Department of Veterans Affairs relating to your eyes or vision? Or have you filed a disability claim with the Social Security Administration or the Department of Veterans Affairs relating to any other medical issue since January 1, 1996?

Yes \_\_\_\_\_ No \_\_\_\_\_

If "Yes" to either question in VII.E, please provide the following for each claim:

1. Are you currently receiving Social Security of VA benefits?

Yes \_\_\_\_ No \_\_\_\_

2. Date claim was filed:

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3. Name and address of the office where the claim was filed:

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4. Claim/file number:

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5. Nature of disability claimed:

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6. Period of disability (please provide beginning and ending date – if ongoing or permanent, so state):

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7. Disposition of the claim, including the amount, date and frequency of any award (if amount is per week, month, year, or other unit of time, provide duration, e.g. \$1,000/month for 24 months):

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8. Name and address of each medical professional who examined you in connection with the claim:

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[Attach additional sheets if necessary to describe more than one claim in any of the above categories]

**VIII. INSTRUCTIONS FOR CONTACT LENS CARE AND USAGE**

A. Were you ever given any written instructions or warnings regarding contact lens care and usage?

Yes \_\_\_ No \_\_\_ Do not recall \_\_\_

1. If "Yes," please attach a copy of the written instructions or warnings.
2. If "Yes," please identify the name and address of the person or business providing such written instructions or warnings.

\_\_\_\_\_  
\_\_\_\_\_

B. Were you ever given any oral instructions or warnings regarding contact lens care and usage?

Yes \_\_\_ No \_\_\_ Do not recall \_\_\_

1. If "Yes," please identify the person or health care provider providing such information.

\_\_\_\_\_

**DECLARATION**

I, \_\_\_\_\_, declare under penalty of perjury that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information, and belief. I understand and am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Signature: \_\_\_\_\_

Hunter J. Shkolnik, Esq.  
Rheingold, Valet, Rheingold, Shkolnik & McCartney, LLP  
113 East 37<sup>th</sup> Street  
New York, NY 10016

**Social Security Administration**  
Consent for Release of Information

TO: Social Security Administration

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

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

NAME: Shook, Hardy & Bacon L.L.P.

Attn: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

I want this information released because: in connection with a legal claim

(There may be a charge for releasing information.)

Please release the following information:

- \_\_\_ Social Security Number
- \_\_\_ Identifying information (includes date and place of birth, parents' names)
- \_\_\_ Monthly Social Security benefit amount
- \_\_\_ Monthly Supplemental Security Income payment amount
- \_\_\_ Information about benefits/payments I received from \_\_\_\_\_ to \_\_\_\_\_
- \_\_\_ Information about my Medicare claim/coverage from \_\_\_\_\_ to \_\_\_\_\_  
(specify) \_\_\_\_\_
- \_\_\_ Medical records
- \_\_\_ Record(s) from my file (specify) \_\_\_\_\_

Other (specify) any records kept by the Social Security Administration

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury 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 gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: \_\_\_\_\_  
(Show signatures, names and addresses of two people if signed by mark.)

Date: \_\_\_\_\_ Relationship: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF PERSONNEL, EMPLOYMENT  
AND UNEMPLOYMENT RECORDS**

TO: \_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State and Zip Code

This authorizes you to release and furnish copies of any and all applications for employment, correspondence, commission reports, sales records, charts, resumes, records of all positions held, salary and/or compensation records, performance evaluations, reviews and reports, statements and comments of fellow employees, attendance records, W-2s, and workers' compensation files concerning

\_\_\_\_\_  
Name of Employee

whose date of birth is \_\_\_\_\_ and whose social security number is \_\_\_\_\_.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

Shook, Hardy & Bacon LLP  
Name of Representative

Attorneys for Bausch & Lomb Incorporated  
Representative Capacity (e.g. attorney, records requester, agent, etc.)

2555 Grand Boulevard. MO 64108  
City, State and Zip Code

\* \* \*

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through as original had been presented to you.

Date: \_\_\_\_\_

\_\_\_\_\_  
Employee or Guardian Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Full Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS  
In Compliance with HIPAA, 45 CFR § 164.508**

TO:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State and Zip Code

You are hereby authorized and directed to release any and all information you may have concerning me to the authorized representative ("Record Requestor") listed below for the purpose of evaluating any claims that I may make against the Record Requestor with respect to any illness or injury, medical history, consultation, prescription or treatment, including x-rays, and copies of all hospital and other medical records, and to make any oral or written reports concerning any treatment given to me at any time.

This release authorizes you to furnish copies of all medical records including but not limited to:

- All medical reports, notes and evaluations, including but not limited to in-patient, out-patient and emergency room treatment, all clinical charts, reports, documents, correspondence, statements, questionnaires/histories, office and doctor's handwritten notes, progress notes and records received by other physicians.
- All laboratory reports, test results, pathology, slides, reports, notes and specimens, histology and cytology.
- All radiographic films, echocardiographic recordings, myelograms, CT scans, X-rays, bone scans, immunohistochemistry specimens, MRI films and reports, MRA films and reports, videotapes, CDs and images of any kind.

- All reports, records or notes regarding the care and treatment of the eye, including but not limited to, optometrist and ophthalmologist medical records, contact lens prescriptions, fundoscopic tests, infectious tests, any photographs of the eye.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All records relating to contact lens prescriptions, including manufacturer and orders for lenses, including retailers/suppliers.
- All billing records including all written statements, itemized bills, insurance records, Medicaid, Medicare and disability records, and medical bills regarding my injuries, diseases, diagnoses or treatment specifically including but not limited to HIV/AIDS testing or treatment, drug testing, drug or alcohol abuse treatment and/or marriage or family counseling.

This authorization does not apply to psychiatric, psychotherapy or psychological notes or records. This authorization is not limited in any way to the records or treatments specified above. This authorization does not permit you to disclose anything other than document and records to anyone. You may not condition treatment, payment, enrollment, or eligibility for benefits on whether this authorization is signed.

You are authorized to release the above information to the following representative of the Record Requestor, Bausch & Lomb, who has agreed to pay reasonable charges made by you to supply copies of records.

Shook, Hardy & Bacon L.L.P.  
Name of Representative

Attorneys for Bausch & Lomb Incorporated  
Representative Capacity (e.g. attorney, record requestor, agent, etc.)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State and Zip Code

I intend that this authorization shall be continuing in nature until any and all claims I may make against Bausch & Lomb are resolved by written agreement executed by both parties. 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 requestor at that time. Further, I hereby agree that a photostatic copy of this authorization may serve as an original.

I understand that any documents or records released by you could potentially be re-disclosed by the aforementioned Record Requestor, and that any information re-disclosed by that party is not subject to this authorization or the regulation imposed by 45 CFR § 164.508.

I understand that I have the right to revoke this authorization at any time by providing to you a written revocation stating my intentions, and if I do exercise such a revocation, I agree to simultaneously provide a copy of such revocation to the Record Requestor. I also understand that any revocation of this authorization shall not affect any disclosures that were made prior to my written revocation.

This authorization is executed and served in compliance with the Federal Regulations governing release of private health information as outlined under 45 CFR § 164.508.

\_\_\_\_\_  
Claimant, Guardian or Personal  
Representative Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Description of the Guardian's or Personal Representative's Authority to Act for the Claimant

**AUTHORIZATION AND RELEASE  
OF INSURANCE RECORDS AND REPORTS**

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

Please be advised that the law firm of SHOOK, HARDY & BACON L.L.P. and any member, associate or designee of those firm are authorized to inspect and copy, or be furnished, any and all recorded information relating to me, including but not limited to:

applications for insurance coverage and renewals; all insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverages; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage, or claims; all physicians, hospital, psychiatric, psychological, and dental reports, prescriptions, correspondence, test results, radiological films and any other medical records that were submitted for claims review purposes; any claim record filed; records of any claim paid; records of all litigation; and any other records of any kind in your possession.

You are hereby released from any and all liability in connection with the disclosure of records, documents, writings and physical evidence from the above named firm.

This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof. Therefore, please accept this Authorization and Release of Insurance Records and Reports *to be continuing in nature and to be supplemented* as new recorded information becomes present and available.

It is expressly understood by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original has been presented to you. Further, this authorization may accompany your standard Authorization and Release and shall be deemed to have the same authority as my signature.

**Printed Name of Insured:** \_\_\_\_\_

Signature: \_\_\_\_\_

**Former/Alias/Maiden Name of Insured:** \_\_\_\_\_

Witness: \_\_\_\_\_

**Date of Birth of Insured:** \_\_\_\_\_

**Social Security Number of Insured:** \_\_\_\_\_

**Address of Insured:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION FOR RELEASE TO INSPECT  
AND COPY WORKERS' COMPENSATION RECORDS**

**TO: Division of Workers' Compensation**

Please be advised that the law firm of **SHOOK, HARDY & BACON L.L.P.** and any member, associate or designee of that firm is authorized to inspect and copy or be furnished copies of the materials in the Workers' Compensation file pertaining to \_\_\_\_\_.

This authorization shall be considered as continuing and you may rely on it in all respects unless you have previously been advised by me in writing to the contrary. It is expressly understood by the undersigned and you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 2007.

Signature: \_\_\_\_\_

\_\_\_\_\_  
Alias/Former Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF NEW YORK

----- X  
IN RE: NEW YORK RENU WITH MOISTURELOC  
PRODUCT LIABILITY LITIGATION  
----- X

Index No. 766,000/2007

THIS DOCUMENT APPLIES TO ALL CASES  
----- X

**FILED**  
JUN - 7 2007  
NEW YORK  
COUNTY CLERK'S OFFICE

**UNIFORM DOCUMENT REQUEST**

**PLEASE TAKE NOTICE** that pursuant to the CPLR, Uniform Court Rules and Case Management Order No. 8, demand is hereby made upon the plaintiff's attorney, to serve upon and deliver to the Defendant simultaneously with the Plaintiff's Fact Sheet, the following documents. Item 1 may be delivered to Defendant on a CD. Items 6 and 7 may be delivered to plaintiffs' counsel who shall be responsible for maintaining custody of the items in the condition received.

**I. DOCUMENTS**

1. A copy of all medical records from any physician, hospital, clinic, healthcare provider or pharmacy that treated the Plaintiff or provided medications for eye-related disorders.
2. If Plaintiff has been the claimant or subject of any worker's compensation, Social Security or other disability proceedings during the time periods described in Section VII of the Plaintiff's Fact Sheet, all documents related to such proceeding.
3. All instructions, packaging, advertising materials, pamphlets, magazine or newspaper articles, internet information, promotional materials, and any other documents that Plaintiff has regarding ReNu® with MoistureLoc®.
4. All instructions or other information regarding contact lens care.
5. The entire packaging, including the bottle and box, for the ReNu® with

MoistureLoc® that you allege caused Plaintiff's injury and any remaining solution.

6. The lens case that Plaintiff was using at the time of the alleged injury from ReNu® with MoistureLoc®.

7. The contact lenses that Plaintiff was using at the time of the alleged injury from ReNu® with MoistureLoc®.

8. Any receipts or other documents that reflect Plaintiff's purchase of ReNu® with MoistureLoc®.

9. If claiming lost wages or a loss of earning capacity, Plaintiff's federal tax returns for each of the last five (5) years and any other documents evidencing lost wages or loss of earning capacity.

10. If Plaintiff claims any loss from medical expenses, copies of all bills or documentation of expenses for which Plaintiff is seeking reimbursement from any physician, hospital, pharmacy, or other health care provider.

11. Copies of letters testamentary or letters of administration relating to Plaintiff's status as Plaintiff.

## **II. AUTHORIZATIONS**

I. Complete and sign the attached authorizations for Release of Medical Records for the medical providers and hospitals identified in this fact sheet.

II. Complete and sign the attached authorizations for Release of Employment and Unemployment Records for the employer(s) identified in the Plaintiff Fact Sheet for whom you were working since January 1, 2001.

III. If Plaintiff has filed a Worker's Compensation or Social Security disability claim during the time period described in Section VII of the Plaintiff Fact Sheet, please complete and sign the attached Authorization for Release of Worker's Compensation and Social Security Records.

IV. Complete and sign the authorization for the release of insurance records relating to Plaintiffs' medical treatment for the last ten (10) years.

Dated: New York, NY  
\_\_\_\_\_, 2007

By: \_\_\_\_\_  
Joseph J. Ortego, Esq.  
NIXON PEABODY, LLP  
Attorneys for Defendant  
50 Jericho Triangle, Suite 300  
Jericho, NY 11753  
Tel. (516) 832-7500  
Fax (516) 832-7555

TO:  
All Attorneys for plaintiffs in the above captioned litigation, and

Paul J. Pennock, Esq.  
Weitz & Luxenberg, P.C.  
180 Maiden Lane  
New York, NY  
Tel. (212) 558-5500  
Fax (212) 344-5461

Jerrold S. Parker Esq.  
Parker & Waichman  
111 Great Neck Road  
Great Neck, NY 11021

Richard J. Arsenault, Esq.  
Neblett, Beard & Arsenault  
2200 Bonaventure Court  
Alexandria, LA 71301

PRESENT:

Honorable Helen E. Freedman, J.S.C.

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF NEW YORK

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:
  
IN RE: NEW YORK RENU WITH MOISTURELOC : Index No. 766 002007  
PRODUCT LIABILITY LITIGATION :  
: **CASE MANAGEMENT**  
: **ORDER NO. 8**  
:
  
----- x  
THIS DOCUMENT APPLIES TO ALL CASES :  
----- x

**ADOPTION OF PLAINTIFF'S FACT SHEET**

The plaintiffs' and defendant's counsel have conferred to develop uniform, agreed-upon discovery to be provided by the plaintiffs in these cases, including: (1) a Plaintiff's Fact Sheet, (2) a uniform set of document requests, and (3) medical, employment and insurance authorizations. The Court has reviewed the proposed Fact Sheet and the Uniform Document Request and all disputes as to the form and content of these have been heard and ruled upon by this Court. Accordingly, it is hereby ORDERED, as follows:

**I. ADOPTION OF PLAINTIFF'S FACT SHEET AND SCHEDULE FOR RESPONSES**

**A. Schedule For Responses**

The attached Plaintiff's Fact Sheet ("PFS" or "Fact Sheet") and the Uniform Document Request ("UDR") are to be completed by all plaintiffs, and the requested medical, employment and insurance authorizations are to be produced to defendant pursuant to the following schedule and procedures.

- a. Plaintiffs' responses shall be served within sixty (60) days of the date of this Order for each of the MoistureLoc cases that are presently before this Court or pending in this proceeding in which Defendant has already filed an answer on the date of entry of this Order.

**FILED**

**JUN - 7 2007**

**NEW YORK  
COUNTY CLERK'S OFFICE**

- b. With respect to cases commenced in this Court after the date of this Order, plaintiffs' responses shall be served within thirty (30) days from the date of the Defendant's answer or sixty (60) days from entry of this Order, whichever is later.
- c. With respect to cases transferred to this Court from other courts within the State after the date of this Order, plaintiffs' responses shall be served within thirty (30) days from the date of the Defendant's answer or sixty (60) days from the date that the case is docketed in this Court, whichever is later.
- d. Each PFS shall be delivered to:

**Eric Anielak, Esq.**  
**Shook, Hardy & Bacon LLP**  
**2555 Grand Blvd.**  
**Kansas City, MO 64108**

**B. Responses Are Binding**

All responses in a PFS are binding on each plaintiff as if they were contained in responses to interrogatories. Each PFS shall be signed and dated by the plaintiff or the proper plaintiff representative under penalty of perjury.

**II. DEPOSITIONS OF PLAINTIFFS**

Subject to the provisions of any further Orders of this Court regarding protocols to be observed in taking depositions, questions at the deposition of a plaintiff shall not seek mere repetition of information provided in that plaintiff's completed Fact Sheet. However, nothing in this Order shall prevent defendant from asking questions directed at correcting, supplementing, updating, explaining, expanding and/or generally confirming the information provided in a completed Fact Sheet to the extent permitted by the CPLR.

**III. PRIVILEGE CLAIMS**

To the extent that any information, documents or authorizations required to be provided in response to the Fact Sheet and UDR are withheld on the grounds of privilege, a privilege log shall be provided of the information, documents, or authorizations withheld. The form and content of any such privilege log shall be governed by CMO 8.

**IV. VALIDITY OF AUTHORIZATIONS**

All authorizations to obtain records provided pursuant to this Order, or any other Order of this Court, shall remain valid during the entire time that the action of the plaintiff who provided the authorization is pending in this Court, any transferor Court, or any Court to which such action is remanded or transferred. No such authorization shall be valid after the action of the

plaintiff who provided the authorization is concluded.

**V. NOTIFICATION OF REQUEST FOR RECORDS**

Whenever defendant requests records pursuant to authorizations provided with the UDR, the principal attorney for that plaintiff, as identified in the completed Fact Sheet, shall be provided with a copy of that request of records.

**VI. ADMISSIBILITY OF INFORMATION PROVIDED VIA FACT SHEET.**

Neither this Order, nor the completion of a Fact Sheet and a response to the UDR, shall prejudice the right of any party to contest the admissibility of any information or documents disclosed.

**VII. USE OF MEDICAL RECORDS**

Medical records obtained pursuant to an executed authorization shall not be disclosed for any purpose outside of this litigation. The foregoing does not limit any party's right to utilize all such records within the confines of this litigation. Such use includes, but is not limited to, examinations before trial and referring to or attaching copies of medical records as exhibits to papers served or filed in this litigation.

**VIII. APPLICABILITY OF ORDER**

This Order shall apply to all cases docketed in the New York ReNu with Moisture Loc Product Liability Litigation and will remain in effect in all such cases after remand to transferor courts.

Dated: June 3, 2007

New York, New York

ENTER:

Helen E. Freedman

Helen E. Freedman, J.S.C.

**FILED**  
JUN - 7 2007  
NEW YORK  
COUNTY CLERK'S OFFICE