IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK

)	MDL Docket No. 3044
IN RE: EXACTECH POLYETHYLENE ORTHOPEDIC PRODUCTS LIABILITY)	THE HON. NICHOLAS G. GARAUFIS, U.S.D.J.
LITIGATION)	PLAINTIFF'S PRELIMINARY DISCLOSURE FORM
	ĺ	22.2

Instructions: Please provide the following information for each individual on whose behalf a claim is being made relating to implantation of an Exactech Device. When providing names and addresses please provide the full name and full address, including street number, street name, city, state and zip code.

I. CA	SE INFORMAT	ΓΙΟΝ	
	Primary Attorney & Contact		
II. PAT	IENT INFORM		
		Date of Birth:	
Street:		Loss of Consortium Claim:	Yes
City:			No
State: Zip:			
xxx-xx-		If yes, name of spouse:	
	Street: City: State: Zip:	Street: City: State: Zip: xxx-xx- rmation of Estate Representative	Attorney & Contact Information: II. PATIENT INFORMATION Date of Birth: Street: City: State: Zip: If yes, name of spouse:

		III.	EXACTECH	I DEVIC	CE IMPI	LANT	INFOR	MATI	ON #1	
Identify Location Body Where Product(s) at Issu		Right hip	Left hip	Both h	ips	No hi _l	p	(check	one)	
Was Implanted:		Right knee	Left knee	Bot	h knees	N	o knee	(check one)	
		Right ankle	Left anklo		oth ankles		No ankl		(check one)	
		ore than one I nation below f								h Device. Fill out the
ti	ijorn	nution below j			mplanta		<u> </u>		ui sneeis us n	
Type of Exactech	Opt	etrak Classic	Optetrak		Trulia		Vanta			
Device: (check one only)	Con	nnexion GXL	Conventi	onal UHN	MWPE H	ip Lin	er			
Expiration Date for Component if Indian or Other Medical	icated	d on Bar Code					Date of Implant			
Catalog No./Lot I for Each Exacted										
Name and Address Implanting Surge			Name:							
			Street:							
			City:					State:		Zip:
Name and Address Facility Where In			Name:							
Performed:			Street:							
			City:					State:		Zip:
			T . £4	Cida I	mlam4a4i	- C				
Type of					plantati					
Exactech	Opt	etrak Classic	Optetrak	Logic	Trulia	ınt	Vanta	ge		
Device: (check one only)	Con	nnexion GXL	Conventi	onal UHN	MWPE H	ip Lin	er			
Expiration Date for the Polyethylene Component if Indicated on Bar Code or Other Medical Records:		d on Bar Code					Date of Implant			
Catalog No./Lot No./Serial No. for Each Exactech Component:										
Name and Address of Implanting Surgeon:			Name:							
, ,			Street:							
			City:					State:		Zip:
Name and Address Facility Where In			Name:							
Performed:			Street:							
			City:					State:		Zin:

IV. EXACTECH DEVICE REVISION SURGERY INFORMATION #1						
	Surg	gery #1	Sur	gery #2	Surg	ery #3
Date of Revision Surgery(ies):						
Name(s) and Address(es) of Explanting Surgeon(s):	Name:		Name:		Name:	
	Street:		Street:		Street:	
	City:		City:		City:	
	State:	Zip:	State:	Zip:	State:	Zip:
Name(s) and Address(es) of Medical Facility(ies) Where Revision	Name:		Name:		Name:	
Surgery(ies) Was Performed:	Street:		Street:		Street:	
	City:		City:		City:	
	State:	Zip:	State:	Zip:	State:	Zip:
Identify the components removed during the revision surgery:						
Are You in Possession of Explanted Component(s)?	Yes	No	Yes	No	Yes	No
Location of Explant(s):						
Identify Location of Body Where Revision	Right hip	Left hip	Right hip	Left hip	Right hip	Left hip
Surgery Was Performed:	Both hips	No hip	Both hips	No hip	Both hips	No hip
	Right knee	Left knee	Right knee	Left knee	Right knee	Left knee
	Both knees	No knee	Both knees	No knee	Both knees	No knee
	Right ankle	Left ankle	Right ankle	Left ankle	Right ankle	Left ankle
	Both ankles	No ankle	Both ankles	No ankle	Both ankles	No ankle

X1 ::0 X	0.1	III.	EXACTECH	DEVIC	E IMPL	ANT	INFOR	MATI	ON #2		
Identify Location Body Where Product(s) at Issu		Right hip	Left hip	Both h	ips N	lo hi	p	(check	one)		
Was Implanted:		Right knee	Left knee	Botl	h knees	N	lo knee	(check one)		
		Right ankle	Left ankle		oth ankles		No ankl		(check one)		
If implanted wi		ore than one I nation below f									fill out the
	ijorn				nplantati				ui sneets us n		
Type of Exactech	Opt	etrak Classic	Optetrak :		Truliar		Vanta				
Device: (check one only)	Con	nnexion GXL	Convention	onal UHN	/IWPE Hij	Lin	er				
Expiration Date for Component if Indian or Other Medical	icated	d on Bar Code					Date of Implan				
Catalog No./Lot I for Each Exacted											
Name and Address Implanting Surge			Name:								
			Street:								
			City:					State:		Zip:	
Name and Address Facility Where In			Name:								
Performed:			Street:								
			City:					State:		Zip:	
			I - 64	C: J. T	14-4-	C	110	•			
Type of	_				plantatio 		<u> </u>				
Exactech	Opt	etrak Classic	Optetrak 1	Logic	Truliar	ıt	Vanta	ge			
Device: (check one only)	Con	nnexion GXL	Convention	onal UHN	⁄IWPE Ніј) Lin					
Expiration Date for the Polyethylene Component if Indicated on Bar Code or Other Medical Records:		d on Bar Code					Date of Implan				
Catalog No./Lot No./Serial No. for Each Exactech Component:											
Name and Address of Implanting Surgeon:		Name:									
		Street:									
		City:					State:		Zip:		
Name and Address Facility Where In			Name:			_					
Performed:	•		Street:								
			City:					State:		Zip:	

IV. EXACTECH DEVICE REVISION SURGERY INFORMATION #2							
	Surg	gery #1	Surg	gery #2	Surg	ery #3	
Date of Revision Surgery(ies):							
Name(s) and Address(es) of Explanting Surgeon(s):	Name:		Name:		Name:		
	Street:		Street:		Street:		
	City:		City:		City:		
	State:	Zip:	State:	Zip:	State:	Zip:	
Name(s) and Address(es) of Medical Facility(ies) Where Revision	Name:		Name:		Name:		
Surgery(ies) Was Performed:	Street:		Street:		Street:		
	City:		City:		City:		
	State:	Zip:	State:	Zip:	State:	Zip:	
Identify the components removed during the revision surgery:							
Are You in Possession of Explanted Component(s)?	Yes	No	Yes	No	Yes	No	
Location of Explant(s):							
Identify Location of Body Where Revision	Right hip	Left hip	Right hip	Left hip	Right hip	Left hip	
Surgery Was Performed:	Both hips	No hip	Both hips	No hip	Both hips	No hip	
	Right knee	Left knee	Right knee	Left knee	Right knee	Left knee	
	Both knees	No knee	Both knees	No knee	Both knees	No knee	
	Right ankle	Left ankle	Right ankle	Left ankle	Right ankle	Left ankle	
	Both ankles	No ankle	Both ankles	No ankle	Both ankles	No ankle	

		III.	EXACTECH	DEVIC	CE IMPL	ANT	INFOR	MATI	ON #3		
Identify Location Body Where Product(s) at Issu		Right hip	Left hip	Both h	ips N	Io hi	p	(check	one)		
Was Implanted:		Right knee	Left knee	Bot	h knees	N	lo knee	(check one)		
		Right ankle	Left ankle	Во	oth ankles		No ankle	•	(check one)		
If implanted wi ii		ore than one I nation below f									Fill out the
			Righ	t Side I	mplantati	on S	urgery #	3			
Type of Exactech Device:	-	etrak Classic	Optetrak l	Logic	Truliar	nt	Vantag	ge			
(check one only)	Con	nexion GXL	Conventio	nal UHN	MWPE Hi _l	Lin	er				
Expiration Date for Component if India or Other Medical 1	icated	l on Bar Code					Date of Implanta				
Catalog No./Lot I for Each Exacted											
Name and Address Implanting Surge			Name:								
1 6 6			Street:								
		26.42.4	City:					State:		Zip:	
Name and Address Facility Where In			Name:								
Performed:			Street:								
			City:					State:		Zip:	
			Left	Side Im	plantatio	n Su	rgery #3				
Type of Exactech	Opt	etrak Classic	Optetrak l	Logic	Truliar	nt	Vantag	ge			
Device: (check one only)	Con	nexion GXL	Convention	nal UHN	MWPE Hip	Lin	er				
Expiration Date for Component if India or Other Medical 1	icated	l on Bar Code					Date of Implanta	ation:			
Catalog No./Lot No./Serial No. for Each Exactech Component:											
Name and Address of Implanting Surgeon:		Name:									
		Street:									
Name and Addre	ag af	Madical	City:					State:		Zip:	
Facility Where In			Name:								
Performed:			Street:								
			City:					State:		Zin·	

	IV. EXACTECH DEVICE REVISION SURGERY INFORMATION #3							
	Sur	gery #1	Sur	gery #2	Surg	ery #3		
Date of Revision Surgery(ies):								
Name(s) and Address(es) of Explanting Surgeon(s):	Name:		Name:		Name:			
	Street:		Street:		Street:			
	City:		City:		City:			
	State:	Zip:	State:	Zip:	State:	Zip:		
Name(s) and Address(es) of Medical Facility(ies) Where Revision	Name:		Name:		Name:			
Surgery(ies) Was Performed:	Street:		Street:		Street:			
	City:		City:		City:			
	State:	Zip:	State:	Zip:	State:	Zip:		
Identify the components removed during the revision surgery:								
Are You in Possession of Explanted Component(s)?	Yes	No	Yes	No	Yes	No		
Location of Explant(s):								
Identify Location of Body Where Revision	Right hip	Left hip	Right hip	Left hip	Right hip	Left hip		
Surgery Was Performed:	Both hips	No hip	Both hips	No hip	Both hips	No hip		
	Right knee	Left knee	Right knee	Left knee	Right knee	Left knee		
	Both knees	No knee	Both knees	No knee	Both knees	No knee		
	Right ankle	Left ankle	Right ankle	Left ankle	Right ankle	Left ankle		
	Both ankles	No ankle	Both ankles	No ankle	Both ankles	No ankle		

V. ADDITIONAL MEDICAL INFORMATION							
Imaging Study(ies)		If yes, list which reports are available:					
Conducted? (e.g., MRI/CT/	Yes	1					
X-Rays)							
TI Tays)	No						
	NO						
D (1 1 C) 1		70 11 1 1					
Pathology Studies		If yes, list which reports and/or					
Conducted?	Yes	specimens are available:					
	105						
	N T						
	No						
		OCUMENTS TO BE ATTACHED					
	ning the product ide	entification and pages with manufacture	r/product stickers for every product				
implanted;							
2. Attach the implant oper	rative report(s);						
3. Attach the revision oper	rative report(s); and	d					
4. Attach the revision path	ology report(s).						
1	<u> </u>						
		D 1					
BY: _		Dated:					
Attorney for Plaintiff:							