

SECTION II-A PRIOR POINTS DETERMINATION

A. List the final number of points Claimant was allocated in connection with the National Settlement Program: _____

B. List the National Compensation Program Claim Number: _____

C. Does Claimant intend to rely on prior points determination for the St. Thomas Tennessee Settlement Program? YES NO (If yes, the Tennessee Settlement Administrator will make no further review, other than to confirm the number of points previously awarded, and will award the same number of points as the final point amount awarded in connection with the National Compensation Program. Claimant waives all rights to appeal or otherwise challenge the points allocation by the Tennessee Settlement Administrator.

D. Claimant must attach documentation evidencing the number of points finally awarded in connection with the National Compensation Program.

E. By checking YES above in Section II-A.C, Claimant consents to the Tennessee Settlement Administrator releasing information to the Tennessee Settlement Administrator related to the final point allocation to Claimant.

F. If Claimant checked YES above in Section II-A.C, Claimant may skip to Section VI.

SECTION III: PRODUCT ADMINISTERED

A. Was the Claimant injected with any of Lots 05212012@68, 06292012@26, and/or 08102012@51 of preservative-free methylprednisolone acetate compounded by New England Compounding Pharmacy (the “Three Contaminated MPA Lots”)?
 YES NO

B. If yes, provide the date, place and lot number(s) of the Claimant’s injection(s) from the Three Contaminated MPA Lots:

_____ - _____ - _____ <i>Date</i>	_____	_____	_____
	<i>State</i>	<i>Clinic, Hospital, or Doctor’s Office</i>	<i>Lot Number</i>
_____ - _____ - _____ <i>Date</i>	_____	_____	_____
	<i>State</i>	<i>Clinic, Hospital, or Doctor’s Office</i>	<i>Lot Number</i>
_____ - _____ - _____ <i>Date</i>	_____	_____	_____
	<i>State</i>	<i>Clinic, Hospital, or Doctor’s Office</i>	<i>Lot Number</i>

C. I am submitting documentary proof of injection from one of the Three Contaminated MPA Lots with this Claim Form. Describe the type of documentary proof (see Instructions Document for types of documentary proof):

D. I do not have documentation of an injection from one of the Three Contaminated MPA Lots. I request that the Tennessee Settlement Administrator review the lists of patients who received an injection from one of the Three Contaminated MPA Lots that were submitted to the Trustee in 2013 by clinics, hospitals and doctor’s offices (“Patient Lists”) in order to establish the necessary proof of injection. I also request that the Tennessee Settlement Administrator review the various state lists of New England Compounding Pharmacy (“NECC”) cases to determine if Claimant’s name is on any of these lists in order to establish the necessary proof of injection.

E. If Claimant did not receive an injection from one of the Three Contaminated MPA Lots but is claiming exposure to a different contaminated lot of NECC product, provide the date, place, name of product, and lot number of the contaminated lot of NECC product(s) that Claimant was administered:

_____ - _____ - _____ <i>Date</i>	_____	_____	_____	_____
	<i>State</i>	<i>Clinic, Hospital, or Doctor’s Office</i>	<i>Product</i>	<i>Lot Number</i>
_____ - _____ - _____ <i>Date</i>	_____	_____	_____	_____
	<i>State</i>	<i>Clinic, Hospital, or Doctor’s Office</i>	<i>Product</i>	<i>Lot Number</i>
_____ - _____ - _____ <i>Date</i>	_____	_____	_____	_____
	<i>State</i>	<i>Clinic, Hospital, or Doctor’s Office</i>	<i>Product</i>	<i>Lot Number</i>
_____ - _____ - _____ <i>Date</i>	_____	_____	_____	_____
	<i>State</i>	<i>Clinic, Hospital, or Doctor’s Office</i>	<i>Product</i>	<i>Lot Number</i>

F. I am submitting the required proof of administration from a contaminated lot of NECC product other than one of the Three Contaminated MPA Lots with this Claim Form. Describe the type of documentary proof:

SECTION IV: BASE POINT CATEGORIES AND UPWARD ADJUSTMENTS

What is the Base Point Category (as defined in the Claims Resolution Facility Procedures) for which you are making a claim? **CHECK ONLY ONE CATEGORY AND PROCEED TO THE APPROPRIATE SUBSECTION FOR THAT CATEGORY BELOW.**

- CATEGORY I: DEATH AFTER MPA INJECTION AND (1) SPINAL OR PARASPINAL FUNGAL INFECTION (including vertebral osteomyelitis, discitis, sacroiliitis, epidural or paraspinal phlegmon, epidural or paraspinal abscess, and/or arachnoiditis) AND/OR (2) FUNGAL MENINGITIS**
- CATEGORY II: NON-DEATH FUNGAL MENINGITIS AND SPINAL OR PARASPINAL FUNGAL INFECTION (including vertebral osteomyelitis, discitis, sacroiliitis, epidural or paraspinal phlegmon, epidural or paraspinal abscess, and/or arachnoiditis) AFTER MPA INJECTION**
- CATEGORY III: NON-DEATH FUNGAL MENINGITIS AFTER MPA INJECTION**
- CATEGORY IV: NON-DEATH SPINAL OR PARASPINAL FUNGAL INFECTION (including vertebral osteomyelitis, discitis, sacroiliitis, epidural or paraspinal phlegmon, epidural or paraspinal abscess, and/or arachnoiditis) AFTER MPA INJECTION, as well as PERIPHERAL JOINT (E.G., HIP, KNEE, SHOULDER, ELBOW, AND/OR ANKLE) FUNGAL INFECTION AFTER MPA INJECTION (previously Category V)**
- CATEGORY V: (Subsumed into Category IV)**
- CATEGORY VI: HEADACHE, WORD-FINDING DIFFICULTY, NAUSEA/VOMITING, FEVER, NECK STIFFNESS OR PAIN, BACK PAIN, PHOTOPHOBIA, LACK OF APPETITE, URINE RETENTION, SLURRED SPEECH, LIMB WEAKNESS, NUMBNESS, AND/OR PAIN AT INJECTION SITE AND A LUMBAR PUNCTURE, MRI, OR CT-GUIDED BIOPSY AFTER MPA INJECTION**
- CATEGORY VII: NO SYMPTOMS OR NO LUMBAR PUNCTURE, MRI, OR CT-GUIDED BIOPSY AFTER MPA INJECTION**

A. CATEGORY I: DEATH AFTER MPA INJECTION AND (1) SPINAL OR PARASPINAL FUNGAL INFECTION (including vertebral osteomyelitis, discitis, sacroiliitis, epidural or paraspinal phlegmon, epidural or paraspinal abscess, and/or arachnoiditis) AND/OR (2) FUNGAL MENINGITIS

1. a. Did the Claimant's death occur after receiving an injection from one of the Three Contaminated MPA Lots?
YES NO . Date of Death: _____- _____ - _____

b. Was there an unrelated event (apart from the injection from one of the Three Contaminated MPA Lots or complications arising therefrom) that resulted in the death (e.g., auto accident, unrelated illness, etc.)?
YES NO

If "yes," please describe the unrelated event(s):

- 2. I am submitting a copy of the Claimant's certified death certificate.
- 3. I am submitting additional documentary proof that the death was the result of the injection from one of the Three Contaminated MPA Lots or complications arising therefrom with this Claim Form. Describe the type of documentary proof:

Check each Upward Adjustment claimed, answer all questions relating to the Upward Adjustment(s) claimed, and indicate whether you are submitting documentary proof for the Upward Adjustment.

4. **Age Adjustment**
What was the age of the Claimant on the date of death? _____

5. **Dependent Children Adjustment**
How many dependent children under 18 did the Claimant have on the date of death? _____

6. I am submitting documentary proof of eligibility for the Dependent Children Adjustment. Describe the type of documentary proof: _____

7. **Spousal Adjustment**
a. Was the Claimant married as of the date of death? YES NO
b. What is the name of the surviving spouse? _____

8. **Adult Children Adjustment**
Please list the name(s), date(s) of birth, and current address(es) of the surviving natural or adopted adult children as of the date of death of Claimant (maximum 3).

<i>Name</i>	<i>Date of Birth</i>	<i>Current Address</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. I am submitting proof of eligibility for the Adult Children Adjustment. Describe the type of documentary proof:

10. **Surgical Debridement or Irrigation Surgery, Laminectomy, Discectomy, or Hemilaminectomy Adjustment**

11. I am submitting documentary proof of eligibility for the Surgical Debridement or Irrigation Surgery, Laminectomy, Discectomy, or Hemilaminectomy Adjustment. Describe the type of documentary proof:

12. **Anti-Fungal Complication Adjustment**
Was the Claimant non-African American or African American ?

13. I am submitting documentary proof of eligibility for the Anti-Fungal Complication Adjustment. Describe the type of documentary proof:

14. **Lengthy Anti-Fungal Treatment Adjustment**
How many days of anti-fungal treatment did the Claimant receive after receiving an injection from one of the Three Contaminated MPA Lots? _____

15. I am submitting documentary proof of eligibility for the Lengthy Anti-Fungal Treatment Adjustment. Describe the type of documentary proof:

16. **Lengthy Hospitalization Adjustment**

a. Was the Claimant hospitalized in an acute care hospital after receiving an injection from one of the Three Contaminated MPA Lots? YES NO . If "yes," for how many nights? _____

b. If "yes," was there any other unrelated event (apart from injection from one of the Three Contaminated MPA Lots or complications arising therefrom) that resulted in any such hospitalization (e.g., auto accident, unrelated illness, etc.) after receiving an injection from one of the Three Contaminated MPA Lots? YES NO . If "yes," please describe the unrelated event(s) and state the number of nights hospitalized as a result of the unrelated event(s):

Number of nights hospitalized as a result of the unrelated event(s): _____

c. Was the Claimant hospitalized in an acute care hospital between January 1, 2012 and June 8, 2012? YES NO . If "yes," please describe the reason(s) for such hospitalization(s):

d. Was the Claimant admitted to an inpatient, long-term acute care, rehabilitation, hospice, or nursing home facility after receiving an injection from one of the Three Contaminated MPA Lots (and after initial hospitalization in an acute care hospital for 5 or more nights)? YES NO . If "yes," for how many nights? _____

e. If "yes," was there any other unrelated event (apart from injection(s) from one of the Three Contaminated MPA Lots or complications arising therefrom) that required any such admission to a long-term acute care, rehabilitation, hospice, or nursing home facility after receiving an injection from one of the Three Contaminated MPA Lots? YES NO . If "yes," describe the unrelated event(s) and state the number of nights the Claimant stayed at an inpatient, long-term acute care, rehabilitation, hospice, or nursing home facility as a result of the unrelated event(s):

Number of nights Claimant stayed in such facility as a result of the unrelated event(s): _____

f. Was the Claimant confined to an inpatient, long-term acute care, rehabilitation, hospice, or nursing home facility between January 1, 2012 and June 8, 2012? YES NO If "yes," please describe the reason(s) for such confinement(s):

17. I am submitting documentary proof of eligibility for the Lengthy Hospitalization Adjustment. Describe the type of documentary proof:

18. **Multiple Lumbar Punctures and/or CT-Guided Biopsies Adjustment**
How many lumbar punctures and/or CT-guided biopsies did the Claimant receive after being injected with one of the Three Contaminated MPA Lots and before September 30, 2013? _____

19. I am submitting documentary proof of eligibility for the Multiple Lumbar Punctures and/or CT-Guided Biopsies Adjustment. Describe the type of documentary proof:

20. **Income Adjustment**
a. Was the Claimant's earned income more than 10% less in 2012 or 2013 as compared to 2011? YES NO If "yes," for how much less? _____
b. If "yes," was there an unrelated reason(s) (apart from the injection from one of the Three Contaminated MPA Lots or complications arising therefrom) for this reduction in earned income (e.g., layoff, forced work reduction, planned retirement, etc.)? YES NO If "yes," please describe the unrelated reasons(s):

21. I am submitting documentary proof of eligibility for the Income Adjustment. Describe the type of documentary proof:

B. CATEGORY II: NON-DEATH FUNGAL MENINGITIS AND SPINAL OR PARASPINAL FUNGAL INFECTION (including vertebral osteomyelitis, discitis, sacroiliitis, epidural or paraspinal phlegmon, epidural or paraspinal abscess, and/or arachnoiditis) AFTER MPA INJECTION

1. I am submitting documentary proof that the Claimant suffered from fungal meningitis AND a spinal or paraspinal fungal infection after receiving an injection from one of the Three Contaminated MPA Lots. Describe the type of documentary proof:

Check each Upward Adjustment claimed, answer all questions relating to the Upward Adjustment(s) claimed, and indicate whether you are submitting documentary proof for the Upward Adjustment.

2. **Sacroiliac Joint Adjustment**

3. I am submitting documentary proof of eligibility for the Sacroiliac Joint Adjustment. Describe the type of documentary proof:

4. **Lengthy Hospitalization Adjustment**

- a. Was the Claimant hospitalized in an acute care hospital after receiving an injection from one of the Three Contaminated MPA Lots? YES NO If "yes," how many nights? _____
- b. If "yes," was there any other unrelated event(s) (apart from the injection from one of the Three Contaminated MPA Lots or complications arising therefrom) that resulted in any such hospitalization (e.g., auto accident, unrelated illness, etc.) after receiving an injection from one of the Three Contaminated MPA Lots? YES NO If yes, please describe the unrelated event(s) and state the number of nights hospitalized as a result of the unrelated event(s):

Number of nights hospitalized as a result of the unrelated event(s): _____

- c. Was the Claimant hospitalized in an acute care hospital between January 1, 2012 and June 8, 2012? YES NO . If "yes," please describe the reason(s) for such hospitalization(s)

:

- d. Was the Claimant admitted to an inpatient, long-term acute care, rehabilitation, hospice, or nursing home facility after receiving an injection from one of the Three Contaminated MPA Lots (and after initial hospitalization in an acute care hospital for 5 or more nights)? YES NO . If "yes," for how many nights? _____

e. If “yes,” was there any other unrelated event(s) (apart from injection(s) from one of the Three Contaminated MPA Lots or complications arising therefrom) that required any such admission to a long-term acute care, rehabilitation, hospice, or nursing home facility after receiving an injection from one of the Three Contaminated MPA Lots? YES NO . If “yes,” describe the unrelated event(s) and state the number of nights the Claimant stayed at an inpatient, long-term acute care, rehabilitation, hospice, or nursing home facility as a result of the unrelated event(s):

Number of nights Claimant stayed in such facility as a result of the unrelated event(s): _____

f. Was the Claimant confined to an inpatient, long-term acute care, rehabilitation, hospice, or nursing home facility between January 1, 2012 and June 8, 2012? YES NO If “yes,” please describe the reason(s) for such confinement(s):

5. I am submitting documentary proof of eligibility for the Lengthy Hospitalization Adjustment. Describe the type of documentary proof:

6. **Surgical Debridement or Irrigation Surgery, Laminectomy, Discectomy, or Hemilaminectomy Adjustment**

7. I am submitting documentary proof of eligibility for the Surgical Debridement or Irrigation Surgery, Laminectomy, Discectomy, or Hemilaminectomy Adjustment. Describe the type of documentary proof:

8. **Anti-Fungal Complication Adjustment**
Is the Claimant non-African American or African American ?

9. I am submitting documentary proof of eligibility for the Anti-Fungal Complication Adjustment. Describe the type of documentary proof:

10. **Lengthy Anti-Fungal Treatment Adjustment**
How many days of anti-fungal treatment did the Claimant receive after receiving an injection from one of the Three Contaminated MPA Lots? _____

11. I am submitting documentary proof of eligibility for the Lengthy Anti-Fungal Treatment Adjustment. Describe the type of documentary proof:

12. **Stroke Adjustment**
a. Was there any other unrelated event(s) (apart from the injection from one of the Three Contaminated MPA Lots or complications arising therefrom) that resulted in the stroke (e.g., unrelated illness)? YES NO If "yes," please describe the unrelated event(s)

b. Did the Claimant suffer a cerebrovascular accident/stroke (not a transient ischemic attack only) before June 8, 2012? YES _____ NO _____

13. I am submitting documentary proof of eligibility for the Stroke Adjustment. Describe the type of documentary proof:

14. **Peripheral Joint Infection Adjustment**

15. I am submitting documentary proof of eligibility for the Peripheral Joint Infection Adjustment. Describe the type of documentary proof:

16. **Arachnoiditis Adjustment and Neurogenic Bowel and/or Bladder Dysfunction Sub-Adjustment**

17. I am submitting documentary proof of eligibility for the Arachnoiditis Adjustment. Describe the type of documentary proof:

18. I am submitting documentary proof of eligibility for the Neurogenic Bowel and/or Bladder Dysfunction Sub-Adjustment. Describe the type of documentary proof:

19. **Vertebral Osteomyelitis Adjustment**

20. I am submitting documentary proof of eligibility for the Vertebral Osteomyelitis Adjustment. Describe the type of documentary proof:

21. **Multiple Lumbar Punctures and/or CT-Guided Biopsies Adjustment**

How many lumbar punctures and/or CT-guided biopsies did the Claimant receive after being injected with one of the Three Contaminated MPA Lots and before September 30, 2013? _____

22. I am submitting documentary proof of eligibility for the Multiple Lumbar Puncture and/or CT-Guided Biopsies Adjustment. Describe the type of documentary proof:

23. **Income Adjustment**

a. Was the Claimant's earned income more than 10% less in 2012 or 2013 as compared to 2011? YES NO . If "yes," how much less? _____

b. If "yes," was there an unrelated reason(s) (apart from the injection from one of the Three Contaminated MPA Lots or complications arising therefrom) for this reduction in earned income (e.g., layoff, forced work reduction, planned retirement, etc.)? YES NO .
If "yes," please describe the unrelated reason(s):

24. I am submitting documentary proof of eligibility for the Income Adjustment. Describe the type of documentary proof:

C. CATEGORY III: NON-DEATH FUNGAL MENINGITIS AFTER MPA INJECTION

1. I am submitting documentary proof that the Claimant suffered from fungal meningitis after receiving an injection from one of the Three Contaminated MPA Lots. Describe the type of documentary proof:

Check each Upward Adjustment claimed, answer all questions relating to the Upward Adjustment(s) claimed, and indicate whether you are submitting documentary proof for the Upward Adjustment.

2. **Lengthy Hospitalization Adjustment**

- a. Was the Claimant hospitalized in an acute care hospital after receiving an injection from one of the Three Contaminated MPA Lots? YES NO If "yes," for how many nights?

- b. If "yes," was there any other unrelated event(s) (apart from the injection from one of the Three Contaminated MPA Lots or complications arising therefrom) that resulted in any such hospitalization (e.g., auto accident, unrelated illness, etc.) after receiving an injection from one of the Three Contaminated MPA Lots? YES NO

If "yes," please describe the unrelated event(s) and state the number of nights hospitalized as a result of the unrelated event(s):

Number of nights hospitalized as a result of the unrelated event(s): _____

- c. Was the Claimant hospitalized in an acute care hospital between January 1, 2012 and June 8, 2012? YES NO

If "yes," please describe the reason(s) for such hospitalization(s):

- d. Was the Claimant admitted to an inpatient, long-term acute care, rehabilitation, hospice, or nursing home facility after receiving an injection from one of the Three Contaminated MPA Lots (and after initial hospitalization in an acute care hospital for 5 or more nights)? YES NO

If "yes," for how many nights? _____

- e. If "yes," was there any other unrelated event (apart from injection(s) from one of the Three Contaminated MPA Lots or complications arising therefrom) that required any such admission to a long-term acute care, rehabilitation, hospice, or nursing home facility after receiving an injection from one of the Three Contaminated MPA Lots? YES _____ NO _____

If "yes," describe the unrelated event(s) and state the number of nights the Claimant stayed at an inpatient, long-term acute care, rehabilitation, hospice, or nursing home facility as a result of the unrelated event(s):

Number of nights Claimant stayed in such facility as a result of the unrelated event(s) _____

f. Was the Claimant confined to an inpatient, long-term acute care, rehabilitation, hospice, or nursing home facility between January 1, 2012 and June 8, 2012? YES NO . If “yes,” please describe the reason(s) for such confinement(s):

3. I am submitting documentary proof of eligibility for the Lengthy Hospitalization Adjustment. Describe the type of documentary proof:

4. **Anti-Fungal Complication Adjustment**
Is the Claimant non-African American or African American ?

5. I am submitting documentary proof of eligibility for the Anti-Fungal Complication Adjustment. Describe the type of documentary proof:

6. **Lengthy Anti-Fungal Treatment Adjustment**
How many days of anti-fungal treatment did the Claimant receive after receiving an injection from one of the Three Contaminated MPA Lots? _____

7. I am submitting documentary proof of eligibility for the Lengthy Anti-Fungal Treatment Adjustment. Describe the type of documentary proof:

8. **Stroke Adjustment**

a. Was there any other unrelated event (apart from the injection from one of the Three Contaminated MPA Lots or complications arising therefrom) that resulted in the stroke (e.g., unrelated illness)? YES NO . If “yes,” please describe the unrelated event(s):

b. Did the Claimant suffer a cerebrovascular accident/stroke (not a transient ischemic attack only) prior to June 8, 2012? YES NO .

9. I am submitting documentary proof of eligibility for the Stroke Adjustment. Describe the type of documentary proof:

10. **Peripheral Joint Infection Adjustment**

11. I am submitting documentary proof of eligibility for the Peripheral Joint Infection Adjustment. Describe the type of documentary proof:

12. **Multiple Lumbar Punctures and/or CT-Guided Biopsies Adjustment**
How many lumbar punctures and/or CT-guided biopsies did the Claimant receive after being injected with one of the Three Contaminated MPA Lots and before September 30, 2013? _____

13. I am submitting documentary proof of eligibility for the Multiple Lumbar Punctures and/or CT-Guided Biopsies Adjustment. Describe the type of documentary proof:

14. **Income Adjustment**

- a. Was the Claimant's earned income more than 10% less in 2012 or 2013 as compared to 2011? YES NO If "yes," how much less? _____
- b. If "yes," was there an unrelated reason(s) (apart from the injection from one of the Three Contaminated MPA Lots or complications arising therefrom) for this reduction in earned income (e.g., layoff, forced work reduction, planned retirement, etc.)? YES NO . If "yes," please describe the unrelated reason(s):

15. I am submitting documentary proof of eligibility for the Income Adjustment. Describe the type of documentary proof:

D. CATEGORY IV: NON-DEATH SPINAL OR PARASPINAL FUNGAL INFECTION (including vertebral osteomyelitis, discitis, sacroiliitis, epidural or paraspinal phlegmon, epidural or paraspinal abscess, and/or arachnoiditis) OR PERIPHERAL JOINT (e.g. hip, knee, shoulder, elbow, and/or ankle) FUNGAL INFECTION AFTER MPA INJECTION

1. I am submitting documentary proof that the Claimant suffered from a spinal or paraspinal or peripheral joint fungal infection after injection from one of the Three Contaminated MPA Lots. Describe the type of documentary proof:

Check each Upward Adjustment claimed, answer all questions relating to the Upward Adjustment(s) claimed, and indicate whether you are submitting documentary proof for the Upward Adjustment.

2. **Sacroiliac Joint Infection Adjustment**

3. I am submitting documentary proof of eligibility for the Sacroiliac Joint Adjustment. Describe the type of documentary proof:

4. **Lengthy Hospitalization Adjustment**

- a. Was the Claimant hospitalized in an acute care hospital after receiving an injection from one of the Three Contaminated MPA Lots? YES NO If "yes," for how many nights? _____
- b. If "yes," was there any other unrelated event(s) (apart from the injection from one of the Three Contaminated MPA Lots or complications arising therefrom) that resulted in any such hospitalization (e.g., auto accident, unrelated illness, etc.) after receiving an injection from one of the Three Contaminated MPA Lots? YES _____ NO _____
If "yes," please describe the unrelated event(s) and state the number of nights hospitalized as a result of the unrelated event(s):

Number of nights hospitalized as a result of the unrelated event(s): _____

- c. Was the Claimant hospitalized at an acute care hospital between January 1, 2012 and June 8, 2012? YES NO
If "yes," please describe the reason(s) for such hospitalization(s):

d. Was the Claimant admitted to an inpatient, long-term acute care, hospice, rehabilitation or nursing home facility after receiving an injection from one of the Three Contaminated MPA Lots (and after initial hospitalization in an acute care hospital for 5 or more nights)? YES NO .
If “yes,” for how many nights? _____

e. If “yes,” was there any other unrelated event(s) (apart from the injection from one of the Three Contaminated MPA Lots or complications arising therefrom) that required any such admission to a long-term acute care, rehabilitation, hospice, or nursing home facility after receiving an injection from one of the Three Contaminated MPA Lots? YES NO .
If “yes,” describe the unrelated event(s) and state the number of nights the Claimant stayed at an inpatient, long-term acute care, rehabilitation, hospice, or nursing home facility as a result of the unrelated event(s):

Number of nights Claimant stayed in such facility as a result of the unrelated event(s): _____

f. Was the Claimant confined to an inpatient, long-term acute care, rehabilitation, hospice, or nursing home facility between January 1, 2012 and June 8, 2012? YES NO .
If “yes,” please describe the reason(s) for such confinement(s):

5. I am submitting documentary proof of eligibility for the Lengthy Hospitalization Adjustment. Describe the type of documentary proof:

6. **Surgical Debridement or Irrigation Surgery, Laminectomy, Discectomy, or Hemilaminectomy Adjustment**

7. I am submitting documentary proof of eligibility for the Surgical Debridement or Irrigation Surgery, Laminectomy, Discectomy, or Hemilaminectomy Adjustment. Describe the type of documentary proof:

8. **Anti-Fungal Complication Adjustment**
Is the Claimant non-African American or African American ?

9. I am submitting documentary proof of eligibility for the Anti-Fungal Complication Adjustment. Describe the type of documentary proof:
10. **Lengthy Anti-Fungal Treatment Adjustment**
How many days of anti-fungal treatment did the Claimant receive after receiving an injection from one of the Three Contaminated MPA Lots? _____
11. I am submitting documentary proof of eligibility for the Lengthy Anti-Fungal Treatment Adjustment. Describe the type of documentary proof:
12. **Peripheral Joint Infection Adjustment**
13. I am submitting documentary proof of eligibility for the Peripheral Joint Infection Adjustment. Describe the type of documentary proof:
14. **Arachnoiditis Adjustment and Neurogenic Bowel and/or Bladder Dysfunction Sub-Adjustment**
15. I am submitting documentary proof of eligibility for the Arachnoiditis Adjustment. Describe the type of documentary proof:
16. I am submitting documentary proof of eligibility for the Neurogenic Bowel and/or Bladder Dysfunction Sub-Adjustment. Describe the type of documentary proof:

17. **Vertebral Osteomyelitis Adjustment**
18. I am submitting documentary proof of eligibility for the Vertebral Osteomyelitis Adjustment. Describe the type of documentary proof:
-
19. **Hip Infection Adjustment**
20. I am submitting documentary proof of eligibility for the Hip Infection Adjustment. Describe the type of documentary proof:
-
21. **Multiple Joint Fungal Infections Adjustment**
22. I am submitting documentary proof of eligibility for the Multiple Joint Fungal Infections Adjustment. Describe the type of documentary proof:
-
23. **Debridement/Incision Surgery, Synovectomy, or Arthroplasty Adjustment**
24. I am submitting documentary proof of eligibility for the Debridement/Incision Surgery, Synovectomy, or Arthroplasty Adjustment. Describe the type of documentary proof:
-
25. **Multiple Lumbar Punctures and/or CT-Guided Biopsies Adjustment**
How many lumbar punctures and/or CT-guided biopsies did the Claimant receive after being injected with one of the Three Contaminated MPA Lots and before September 30, 2013? _____
26. I am submitting documentary proof of eligibility for the Multiple Lumbar Punctures and/or CT-Guided Biopsies Adjustment. Describe the type of documentary proof:

27.

Income Adjustment

- a. Was the Claimant's earned income more than 10% less in 2012 or 2013 as compared to 2011?
YES NO If "yes," much less? _____
- b. If "yes," was there an unrelated reason(s) (apart from the injection from one of the Three Contaminated MPA Lots or complications arising therefrom) for this reduction in earned income (e.g., layoff, forced work reduction, planned retirement, etc.)? YES NO .
If "yes," please describe the unrelated reason(s):

28.

I am submitting documentary proof of eligibility for the Income Adjustment. Describe the type of documentary proof:

E. [Category V is subsumed into Category IV]

F. **CATEGORY VI: HEADACHE, WORD-FINDING DIFFICULTY, NAUSEA/VOMITING, FEVER, NECK STIFFNESS OR PAIN, BACK PAIN, PHOTOPHOBIA, LACK OF APPETITE, URINE RETENTION, SLURRED SPEECH, LIMB WEAKNESS, NUMBNESS, AND/OR PAIN AT INJECTION SITE AND A LUMBAR PUNCTURE, MRI, OR CT-GUIDED BIOPSY AFTER MPA INJECTION**

1. I am submitting documentary proof that the Claimant suffered from headache, word-finding difficulty, nausea/vomiting, fever, neck stiffness or pain, back pain, photophobia, lack of appetite, urine retention, slurred speech, limb weakness, numbness, and/or pain at the injection site AND that a lumbar puncture, MRI, or CT-guided biopsy was administered to the Claimant, but there was no diagnosis of fungal meningitis, spinal or paraspinal fungal infection, or peripheral joint fungal infection after injection from one of the Three Contaminated MPA Lots. Describe the type of documentary proof:

Check each Upward Adjustment claimed, answer all questions relating to the Upward Adjustment(s) claimed, and indicate whether you are submitting documentary proof for the Upward Adjustment.

2. **Multiple Lumbar Punctures and/or CT-Guided Biopsies Adjustment**
How many lumbar punctures and/or CT-guided biopsies did the Claimant receive after being injected with one of the Three Contaminated MPA Lots and before September 30, 2013? _____
3. I am submitting documentary proof of eligibility for the Multiple Lumbar Puncture and/or CT-Guided Biopsies Adjustment. Describe the type of documentary proof:

4. **Hospitalization Adjustment**
- a. Was the Claimant hospitalized at an acute care hospital after receiving an injection from one of the Three Contaminated MPA Lots and before April 30, 2013? YES NO .
If "yes," for how many nights? _____
- b. If "yes," was there any other unrelated event(s) (apart from the injection from one of the Three Contaminated MPA Lots or complications arising therefrom) that resulted in any such hospitalization (e.g., auto accident, unrelated illness, etc.) after receiving an injection from one of the Three Contaminated MPA Lots and before April 30, 2013? YES NO .
If "yes," please describe the unrelated event(s) and state the number of nights hospitalized as a result of the unrelated event(s):

Number of nights hospitalized as a result of the unrelated event(s): _____

- c. Was the Claimant hospitalized at an acute care hospital between January 1, 2012 and June 8, 2012? YES NO .
If "yes," describe the reason(s) for such hospitalization(s):

5. I am submitting proof of eligibility for the Hospitalization Adjustment. Describe the type of documentary proof:
6. **Anti-Fungal Treatment Adjustment**
How many days of anti-fungal treatment did the Claimant receive after receiving an injection from one of the Three Contaminated MPA Lots and before September 30, 2013? _____
7. I am submitting documentary proof of eligibility for the Anti-Fungal Treatment Adjustment. Describe the type of documentary proof:
8. **Anti-Fungal Complication Adjustment**
Is the Claimant non-African American or African American ?
9. I am submitting documentary proof of eligibility for the Anti-Fungal Complication Adjustment. Describe the type of documentary proof:
10. **Additional Diagnostic Testing Adjustment**
How many MRIs and/or CT Scans did the Claimant receive after being injected with one of the Three Contaminated MPA Lots and before October 31, 2013? _____
11. I am submitting documentary proof of eligibility for the Additional Diagnostic testing Adjustment. Describe the type of documentary proof.
12. **Surgical Treatment Adjustment**
Did the Claimant undergo surgical procedure undertaken following an MRI and/or CT Scan for exploration of a lumbar abscess, cyst, or other thickening after injection from one of the Three Contaminated MPA Lots and before January 1, 2013? YES NO
13. I am submitting documentary proof of eligibility for the Surgical Treatment Adjustment. Describe the type of documentary proof:

14. **Real-Time PCR Test Adjustment**

Did the Claimant undergo a real-time PCR Test with positive fungal results? YES NO

15. I am submitting documentary proof of eligibility for the Real-Time PCR Test Adjustment. Describe the type of documentary proof:

G. CATEGORY VII: NO SYMPTOMS OR NO LUMBAR PUNCTURE, MRI, OR CT-GUIDED BIOPSY AFTER MPA INJECTION: If you are applying for Base Point Category VII, no additional documentation is required.

SECTION V: CLAIMS INVOLVING BACTERIAL INFECTION AND/OR BACTERIAL MENINGITIS

- A. Are you making a claim for a bacterial infection and/or bacterial meningitis? YES NO
- B. If “yes,” which of the Base Point Categories I–V listed in Section IV of this Claim Form are you applying for? _____
- C. Did the Claimant have any bacterial infections and/or bacterial meningitis that were not the result of being administered a contaminated NECC product during the five-year period prior to being administered a contaminated NECC product? YES NO
If “yes,” please describe the type and cause:

SECTION VI: RELEASE OF MEDICAL INFORMATION

I request that the Tennessee Settlement Administrator review the state lists of cases linked to the Three Contaminated MPA Lots. I, [insert name] _____ authorize any state department of public health to disclose to the Tennessee Settlement Administrator any health information concerning the Claimant on whose behalf this claim is made. I also request the Tennessee Settlement Administrator to review the Patient Lists that were provided to the Trustee in 2013 by clinics, hospitals, and doctors’ offices. I understand that the information disclosed pursuant to this authorization could be subject to redisclosure by the Tennessee Settlement Administrator and, if so, may not be subject to federal or state law protecting its confidentiality. I understand that I may revoke this authorization at any time by requesting such of the Tennessee Settlement Administrator in writing, unless action has already been taken in reliance upon it. Please list the state(s) in which Claimant resided between June 9, 2012 and September 30, 2013:

If the name of the Claimant was different between June 9, 2012 and September 30, 2013, please provide the previous name(s):

SECTION VII: CONFIRMATION OF RELEASE OF CLAIMS AND CERTIFICATION OF NO ASSIGNMENT

I certify that I have not transferred my right to recover compensation from such Parties with respect to my Tort Claim such that the claim can be asserted by another person or entity. I understand that the fact that a Claimant or Representative has executed a “subrogation agreement” with a health insurer or that a statutory provision grants to any governmental entity rights of subrogation shall not of itself be construed as a transfer of the Claimant’s or Representative’s right to recover.

SECTION VIII: TOTAL AMOUNT OF POINTS CLAIMED

I am filing a claim for a total of _____ points, and I am submitting a Calculation Worksheet for the Base Point Category (and adjustments) for which I have made a claim.

SECTION IX: COMPLETED W-9 FORM

I am attaching a completed and signed Form W-9.

SECTION X: CERTIFICATION

Identification of person signing this St. Thomas Tennessee Compensation Claim Form (**check one only**):

- I am the above-identified Claimant. I am signing this Compensation Claim Form to make a claim to the St. Thomas Tennessee Settlement Fund.
- I am the guardian, custodian, executor, administrator, or other court-appointed representative of the above-identified Claimant (or Claimant’s estate). I am signing this Claim Form to make a claim on Claimant’s behalf (or on behalf of Claimant’s estate) to the St. Thomas Tennessee Settlement Fund. [Attach a copy of the court order appointing you as representative or other document establishing such authority. Signature of an attorney (unless serving as court-appointed representative) is not acceptable.]

I consent and understand that, if I have provided the name, address, and tax ID of an attorney in Section I above, settlement checks will be made payable jointly to the attorney (or law firm) and myself.

I declare under penalty of perjury that the information on this St. Thomas Tennessee Claim Form is true, correct, and complete to the best of my knowledge, information, and belief.

Date Signed

Signature of Claimant or Representative

If the Claim is filed by a Representative:

Current Name and Address of Representative

This Claim Form (along with a completed Form W-9 and supporting documentation) must be RECEIVED by the St. Thomas Tennessee Settlement Administrator no later than November 30, 2016. Please send your completed Compensation Claim Form, the required supporting documentation, and a completed Form W-9 to the following address:

Perry, Balhoff, Mengis & Burns, LLC
P.O. Box 80238
Baton Rouge, LA 70808
Attn: Tennessee Settlement Administrator

If you are using a commercial carrier service (such as UPS or FedEx), you should send your completed Claim Form, Form W-9, and Supporting Documentary Proof to the following address:

Pery, Balhoff, Mengis & Burns, LLC
2141 Quail Run Drive
Baton Rouge, LA 70808
Attn: Tennessee Settlement Administrator

In addition to sending a hard copy to the Settlement Administrator, please send an electronic copy of the completed Claim Form, and all attachments to the following email address:

balhoff@pbmbllc.com

If the attachments are too large to send by email, please indicate that in the transmittal email, but make sure to include the attachments with the mailed hard copy.

If your address changes or the information that you provided on your completed Form W-9 changes after you file this Claim Form, please notify the Settlement Administrator. If you have questions about using or completing this Form, contact your attorney or call _____.