Friend/Family Member Statement About
Inadequate Medical Treatment for Damages Class Member

This form, referenced in Question 4 of the Damages Class Claim Form, is an opportunity for a family member or friend of a Damages Class Member to provide information in support of one or more of the Class Member's Damages Claim(s). Please answer the following questions:

(1) Please provide your contact information:

_____ _____ _____/____/_____
First Name Last Name Date of Birth (Month Day Year)

_____ _____
Address Email Address

_____, _____ _____ (____) _____
City State Zip Daytime Telephone number

_____ (____) _____
Class Member/Claimant's Name Evening Telephone number

_____
Relationship to Class Member/Claimant

(2) Please identify the claim or claims (*i.e.*, the medical condition or conditions) concerning which you are submitting this statement, describing in detail that condition (or those conditions) and its (or their) effect on the Damages Claim Member, including the basis for your knowledge of same (*e.g.*, direct observation, descriptions by the Class Member, *etc.*). (You may submit additional pages as necessary).

_____

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In submitting this statement/form, I hereby:

(1) Certify that the information provided above is based on my personal knowledge; and

(2) Pursuant to 28 United States Code § 1746, declare or affirm under penalty of perjury that the information provided above is true and correct to the best of my knowledge.

By: _____
(your signature)