PHYSICIAN VERIFICATION AND DDR ACKNOWLEDGEMENT

This Form must be completed by a Board-Certified Cardiologist, or a Board-Certified Cardiothoracic Surgeon, with at least Level 2 training in Echocardiography. Print or type all information in black ink.

I. DIET DRUG RECIPIENT

Name:	First	Middle	Last
Claim Number		Date of Birth ______/______/______ (Month) (Day) (Year)	Social Security Number __________-________-__________

II. ATTESTING PHYSICIAN REVIEW OF MEDICAL HISTORY AND RECORDS

I certify that:

1. ☐ I am a Board-Certified Cardiologist, or Board-Certified Cardiothoracic Surgeon, with at least Level 2 training in Echocardiography as specified in A.S. Pearlman *et al*., *Guidelines for Optimal Physician Training in Echocardiography: Recommendation of the American Society of Echocardiography Committee on Physician Training in Echocardiography*, 60 Am J. Cardiology 158-163 (1987).

2. ☐ I completed and signed on _______________________________(insert date) the GREEN Form previously submitted to the Settlement Trust by this Diet Drug Recipient.
OR
☐ I completed and signed Part II.E of the GREEN Form attached to this Form.

3. ☐ I met with the Diet Drug Recipient in person in my offices (or in a hospital or other health care facility) on _______________________(insert date) for ______________________ (state length of session) and took a complete medical history of the Diet Drug Recipient, in conformity with accepted medical standards regarding obtaining a medical history for purposes of diagnosis and treatment of a patient with or suspected of having valvular heart disease. I asked the questions and follow-up questions necessary to provide complete and accurate answers to the questions in Part II.E of the GREEN Form. Where the Diet Drug Recipient was unable to answer a question with certainty, I obtained and reviewed the medical records necessary to provide the requested information. There were no agents and/or representatives of any law firm present during my meeting with this Diet Drug Recipient. **Note:** You must attach your written transcription of this medical history to this Form. Lack of information cannot be the basis for a negative answer to any Green Form question.
OR

4. ☐ I met with the Diet Drug Recipient in person in a _______________________________________ (state type of location, i.e., hotel, clinic, mobile unit, etc.) located at ____ (state specific address) on ____________________________(insert date) for _______________________(state length of session) and took a complete medical history of the Diet Drug Recipient, in conformity with accepted medical standards regarding obtaining a medical history for purposes of diagnosis and treatment of a patient with or suspected of having valvular heart disease. I asked the questions and follow-up questions necessary to provide complete and accurate answers to the questions in Part II.E of the GREEN Form. Where the Diet Drug Recipient was unable to answer a question with certainty, I obtained and reviewed the medical records necessary to provide the requested information. This meeting did not take place in an office associated with any law firm and there were no agents and/or representatives of any law firm present during my meeting with this Diet Drug Recipient. **Note:** You must attach your written transcription of the medical history to this Form. Lack of information cannot be the basis for a negative answer to any GREEN Form question.
OR

5. ☐ After reasonable inquiry regarding the existence and completeness of such records, I personally reviewed medical records of the Diet Drug Recipient beginning at least five years preceding the Diet Drug Recipient's Diet Drug use and continuing through the submission of the claim to the Trust, including all records and documents of the general care providers (general practitioners, family physicians, primary care providers, and internists) and all subspecialty care providers (including without limitation subspecialists in internal medicine, cardiovascular and neurological surgeons, neurologists, cardiologists, rheumatologists, pathologists, emergency care providers, obstetricians, and gynecologists), who rendered any medical care to and/or were consulted by the Diet Drug Recipient, and satisfied myself that based on that review I could accurately answer the questions in the GREEN Form or in the attached GREEN Form Part II.E.

NOTE: To complete this Form you must answer Questions 1 and 2. You must also answer Question 3, 4 or 5. If you are *not* the physician who attested to the GREEN Form on file, you must complete, sign, and attach Part II.E of a GREEN Form.

III. PHYSICIAN INFORMATION

Name:	First	Middle	Last	
Address:	Street	City	State	Zip code
Telephone: (_______) ____________________		Fax: (______) _______________	Email:	

NOTE: This Form is an official Court document sanctioned by the Court presiding over the Diet Drug Settlement. Submitting it to the AHP Settlement Trust is equivalent to filing it with a Court. I declare under penalty of perjury that the information I have provided in this Form is correct to the best of my knowledge and information.

Signature: ____ Date:________/_________/_________
(Month) (Day) (Year)

IV. DIET DRUG RECIPIENT ACKNOWLEDGMENT

NOTE: You must complete Question 1 or Question 2, and sign and date this Form.

I certify that:

1. ***Answer this Question if the physician answered Question 3 or 4 in Section II of this Form:***

☐ I met in person on ____________ (insert date) with the physician who completed Sections II and III of this Form. I answered all of his/her questions honestly and completely. I reviewed the physician's answers to the questions on my GREEN Form and affirm that the answers are correct to the best of my knowledge and information.

2. ***Answer this Question if the physician answered Question 5 in Section II of this Form:***

☐ I produced to the physician who completed Sections II and III of this Form, or authorized production to such physician, of my medical records beginning at least five years preceding my Diet Drug use and continuing through the submission of my claim to the Trust, including all records and documents of the general care providers (general practitioners, family physicians, primary care providers, and internists) and all subspecialty care providers (including without limitation subspecialists in internal medicine, cardiovascular and neurological surgeons, neurologists, cardiologists, rheumatologists, pathologists, emergency care providers, obstetricians, and gynecologists), who rendered any medical care to and/or were consulted by me during that period.

NOTE: This Form is an official Court document sanctioned by the Court presiding over the Diet Drug Settlement. Submitting it to the AHP Settlement Trust is equivalent to filing it with a Court. I declare under penalty of perjury that the information provided in this Form is correct to the best of my knowledge and information.

Signature: ____ Date:____________/_____________/_____________
(Month) (Day) (Year)