

# GRAY FORM

## Diet Drug Settlement With American Home Products Corporation

This GRAY FORM is to be used by any Class Member who: (1) is claiming Fund A Settlement Benefits based upon an Echocardiogram performed after September 30, 1999; (2) would like to use this form to document a diagnosis of FDA Positive or Mild Mitral Regurgitation for purposes of preserving the right to seek Matrix-Level Benefits in the future; or (3) would like to document the results of an Echocardiogram for purposes of an Intermediate or Back-End Opt-Out. For these purposes, this GRAY FORM must be completed by a Cardiologist or Cardiothoracic Surgeon.

This GRAY FORM may also be used to report on the results of an Echocardiogram in connection with a present Claim for Matrix-Level Benefits. If used for that purpose, it must be completed by a Board-Certified Cardiologist or Board-Certified Cardiothoracic Surgeon with level 2 training in echocardiography.

For any of the foregoing purposes, if the same information has been provided to the AHP Settlement Trust previously on a GREEN FORM, this GRAY FORM need not be completed and submitted.

**1. Name, office address, telephone number, and E-mail address, if any, of the physician completing form.**

\_\_\_\_\_  
(First Name) (Middle Initial) (Last Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

( ) \_\_\_\_\_  
(Daytime Area Code & Phone Number) (Evening Area Code & Phone Number)

\_\_\_\_\_  
(E-mail Address, if any)

- 2. a. Are you Board-Certified in either cardiology or cardiothoracic surgery?**  
 Yes  No
- b. Do you have level 2 training in echocardiography as specified in the "Recommendations of the American Society of Echocardiography Committee on Physician Training in Echocardiography"<sup>1</sup>?**  
 Yes  No

**3. This form relates to the results of an Echocardiogram performed on the following individual:**

\_\_\_\_\_  
(First Name) (Middle Initial) (Last Name)

\_\_\_\_\_  
(Social Security Number of the individual who was the subject of the Echocardiogram — if known)

18300 - \_\_\_\_\_ (Claim Number of the individual who was the subject of the Echocardiogram—if known)

- 4. Did the above-named patient have an Echocardiogram which was conducted in accordance with the standards and criteria as outlined in Feigenbaum<sup>2</sup> (1994) or Weyman<sup>3</sup> (1994)?**  
 Yes  No
- 5. If the answer to Question #4 is "Yes," state the date when the Echocardiogram was performed.**  
\_\_\_\_\_  
(Date of Echocardiogram MM/DD/YYYY)



