

UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA

IN RE: ROUNDUP PRODUCTS  
LIABILITY LITIGATION

MDL No. 2741

Case No. 16-md-02741-VC

This document relates to:

ALL ACTIONS

**PRETRIAL ORDER NO. 49:  
RE PLAINTIFF FACT SHEETS AND  
UPCOMING DEADLINES**

As discussed at the September 13, 2018, case management conference, a telephonic case management conference is scheduled for September 24, 2018, at 10:00 a.m. By 5:00 p.m. on September 20, 2018, the parties are directed to submit:

1. Any objections to the proposed plaintiff fact sheet attached to this order. The parties should avoid repeating objections that were already raised at the prior case management conference.
2. An explanation of how the parties plan to make the plaintiff fact sheet available for completion online.
3. A proposed pretrial and trial schedule for the four Northern District of California plaintiffs. Note that the pre-trial and trial dates should be the same for all four plaintiffs.
4. A proposed order outlining the procedures for completing the plaintiff fact sheets (including what a plaintiff must do to seek an extension) and the consequences for plaintiffs who do not timely complete fact sheets. The order should specify the separate deadlines for submitting the plaintiff fact sheets for: (a) the four plaintiffs who originally

filed their cases in the Northern District of California (28 days); (b) the other plaintiffs who reside in California (60 days); (c) the remainder of the current plaintiffs (120 days); and (d) plaintiffs whose cases have not yet been transferred to the MDL (90 days from the date of transfer).

5. A proposed defendant fact sheet, along with an explanation of the purposes of a defendant fact sheet in this context. If the parties cannot agree on a fact sheet, the plaintiffs and Monsanto may submit competing fact sheets.

**IT IS SO ORDERED.**

Dated: September 17, 2018



---

VINCE CHHABRIA  
United States District Judge

UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA

IN RE: ROUNDUP PRODUCTS  
LIABILITY LITIGATION

MDL No. 2741

This document relates to:  
ALL ACTIONS

Case No. 16-md-02741-VC

**PROPOSED PLAINTIFF FACT SHEET**

You are required to provide the following information regarding yourself, or for each individual on whose behalf you are asserting legal claims in the above lawsuit. Each question must be answered in full, but you may approximate where specified below. If you do not know or cannot recall the information needed to answer a question, please indicate that in response to the question. Please do not leave any questions unanswered or blank, and use additional sheets as needed to fully respond.

**I. REPRESENTATIVE CAPACITY**

A. If you are completing this Fact Sheet **on behalf of someone else** (e.g., a deceased person, an incapacitated person, or a minor), please complete the following:

1. \_\_\_\_\_  
Your Name
2. \_\_\_\_\_  
Your Home Address
3. What is your relationship to the person upon whose behalf you have completed this Fact Sheet? (e.g., parent, guardian, Estate Administrator)  
  
\_\_\_\_\_

**[If you are completing this questionnaire in a representative capacity, please respond to the remaining questions on behalf of the person who used or was exposed to Roundup® or other glyphosate-based herbicides.]**

**II. PERSONAL INFORMATION**

A. Name: \_\_\_\_\_

Other Names by which you have been known (from prior marriages or otherwise, if any): \_\_\_\_\_

B. Sex: \_\_\_\_\_

C. Social Security Number: \_\_\_\_\_

D. Driver's License Number: \_\_\_\_\_

State of Issuance: \_\_\_\_\_

E. Date and Place of Birth (City, State, Country):

\_\_\_\_\_

F. For each different city where you have lived for the past twenty-five (25) years, provide the following information:

<b>City and State (include Country if outside the United States)</b>	<b>Approximate Dates You Lived There (Month/Year to Month/Year)</b>

G. Please complete the chart below detailing your employment history for the past twenty-five (25) years. If there were periods of retirement, unemployment, or student status during the past 25 years, including those as well.

<b>Number</b>	<b>Name of Employer</b>	<b>City and State Where You Worked</b>	<b>Approximate Dates of Employment (Month/Year to Month/Year)</b>	<b>Occupation or Job Title</b>	<b>Job Duties</b>
1					
2					
3					
4					

H. Workplace Checklist: Have you ever worked in any of the occupations or workplaces listed below? If so, please check “yes” and then list the number(s) in the chart in section (G) above that corresponds to that occupation.

<b>Industry</b>	<b>Yes</b>	<b>No</b>	<b>Number in Chart in Section G (see above)</b>
Car Mechanic			
Cleaning/Maid Service			
Electrician			
Farming/agricultural			
Hairdressing			
Handled fission products			
Handled jet propellant			
Handled solvents			
Horticultural			
Hospitals and Clinics			
Landscaping			
Metal Working			
Painting			
Pest Exterminator			
Pesticide use			
Petroleum Refinery			
Rubber Factory			
Schoolteacher			
Textile			
Woodworking			
X-radiation or gamma-radiation (regular exposure)			

**III. FAMILY INFORMATION**

A. For any grandparent, parent, sibling, or child who has been diagnosed with cancer or who has died, please provide the following information. Please include any adopted or step-children or siblings.

Name	Relationship	Approximate Birth Year	Approximate Date of Death	Cause of Death	Diagnosed with cancer?	Date/Type

**IV. PERSONAL MEDICAL HISTORY**

A. To the best of your ability, please list all healthcare providers (not including pharmacies) where you have received treatment over the last 25 years. For each, please provide the name, city and state, approximate dates of care, and the reason for your visit. **Please also execute the medical authorizations included in Exhibit A.**

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_
5. \_\_\_\_\_  
\_\_\_\_\_
6. \_\_\_\_\_  
\_\_\_\_\_

- B. Please indicate whether your medical history includes any of the following conditions, procedures, or medications:

Condition, Procedure, or Medication:	Yes	No	Treating Physician
Diabetes			
Obesity			
Auto-immune diseases (including but not limited to Crohn's disease, Ulcerative Colitis, HIV)			
Epstein Barr			
Lupus			
Rheumatoid Arthritis			
Organ, stem cell, or other transplant			
Immunosuppressive Medications			

**V. CANCER HISTORY**

- A. Have you been diagnosed with non-Hodgkin's lymphoma, or "NHL"?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- B. When were you first diagnosed with NHL?  
Year \_\_\_\_\_ Month \_\_\_\_\_
- C. Approximately when did you first begin experiencing symptoms of NHL?  
Year \_\_\_\_\_ Month \_\_\_\_\_
- D. Please list the names of the physician(s) that first diagnosed you with NHL.  
\_\_\_\_\_
- E. Please list the names of the primary oncologist(s) who have treated your NHL.  
\_\_\_\_\_
- F. Describe your NHL. For example, do you have B-cell or T-cell NHL? Is it aggressive or indolent? Small cell or large cell? Any other details? (If you have Mycosis Fungoides, make sure to specify this.)  
\_\_\_\_\_

G. Have you been diagnosed with any types of cancer other than NHL?

Yes \_\_\_\_\_ No \_\_\_\_\_

H. **If yes**, please answer the following questions for each type of cancer that you have been diagnosed with other than NHL:

1. What type of cancer was diagnosed (including sub-type, if applicable)?

\_\_\_\_\_

2. On approximately what date did you first experience any symptoms that you believe are related to that cancer?

\_\_\_\_\_

3. Please list the names of the physician(s) that first diagnosed you with that cancer.

\_\_\_\_\_

4. Please list the names of the primary oncologist(s) who have treated that cancer.

\_\_\_\_\_

I. Has any physician or healthcare provider ever told you that you have a genetic predisposition for developing NHL or other types of cancer?

**If yes**, answer the following:

1. Name, location (city and state), and occupation of the person who told you this.

\_\_\_\_\_

2. What were you specifically told about your genetic predisposition?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Approximately when were you told this information?

\_\_\_\_\_



**VI. PRIOR CLAIMS, LEGAL MATTERS, AND MEDICAL COVERAGE**

- A. Have you ever filed a workers' compensation claim for accidents or injuries relating to substance exposure in the workplace? (Answer "no" if you have only filed workers' compensation claims **unrelated to** substance exposure.)

Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes, please state:**

1. Approximate date the claim was filed with your employer, or date that you notified employer of accident/injury giving rise to workers' compensation claim:

\_\_\_\_\_

2. Nature of injury or accident claimed (what happened):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- B. Have you ever filed a claim for Social Security disability insurance benefits ("SSDI") for a disability caused by substance exposure in the workplace? (Answer "no" if you have only filed SSDI claims **unrelated to** substance exposure.)

Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes, please state:**

1. Approximate date the claim was filed with the Social Security Administration:

\_\_\_\_\_

2. Nature of disability giving rise to claim:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Have you ever filed any other type of disability claim for a disability caused by substance exposure in the workplace? (Answer “no” if you have only filed other disability claims **unrelated to** substance exposure.)

Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes**, please state:

1. Approximate date claim was filed: \_\_\_\_\_

2. Name of insurer/employer/government or other party to whom claim was made and, if applicable, claim number assigned:

\_\_\_\_\_  
\_\_\_\_\_

3. Nature of disability giving rise to claim:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. Have you ever been denied life insurance for reasons relating to your medical, physical, psychiatric or emotional condition?

Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes**, please state when, the name of the company, and the reason(s) for denial.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E. Have you ever been denied medical insurance?

Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes**, please state when, the name of the company, and the reason(s) for denial.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. Have you ever **filed** a lawsuit or claim (**including administrative charges, unemployment claims, and bankruptcy petitions**) against anyone aside from the present lawsuit?

Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes**, for each lawsuit, state (1) the court in which the lawsuit was filed; (2) the case name; (3) the civil action or docket number assigned to the lawsuit; (4) a description of your claims in the lawsuit; and (5) the final result, outcome, or adjudication of claims (*e.g.*, whether the lawsuit was dismissed by parties, dismissed by court, judgment granted in favor of a party).

---

---

---

---

---

**VII. ROUNDUP<sup>®</sup> AND OTHER GLYPHOSATE-BASED HERBICIDES**

A. Have you used Roundup<sup>®</sup> or other glyphosate-based products?

Yes \_\_\_\_\_ No \_\_\_\_\_

B. When did you first begin using Roundup<sup>®</sup> or other glyphosate-based products?

Year \_\_\_\_\_ Month \_\_\_\_\_

C. Please complete the chart below to detail your exposure to Roundup® and other glyphosate-based products. Use as many rows as necessary to describe different periods of usage.

<b>Dates of Usage</b>	<b>Product Name (Please specify which products are Roundup® products.)</b>	<b>Frequency of Exposure</b>	<b>Usage</b>	<b>Reason for Usage</b>	<b>Location of Exposure (City and State)</b>
Example: 1980-1985	Example: Roundup® Grass and Weed Killer	Example: Once per week	Example: I sprayed Roundup® in my yard using a hand sprayer.	Example: To control weeds on my personal property.	Example: Oakland, CA

D. Describe any precautions you took while using these products (examples: wearing gloves, a mask, or other protective gear).

---



---



---

E. For the products identified in the chart above, do you have the receipts, proof of purchase, or store of purchase for each product you claim to have used?

Yes \_\_\_\_\_ No \_\_\_\_\_

**To the extent you have receipts, proof of purchase, or store of purchase for these products, please provide copies of those receipts and other documents.**

F. Please complete the chart below to detail your exposure to other herbicides or pesticides. Use as many rows as necessary to detail different periods of usage.

<b>Dates of Usage</b>	<b>Type and Brand of Herbicide or Pesticide</b>	<b>Frequency of Exposure</b>	<b>Usage</b>	<b>Reason for Usage</b>
Example: 2000-2010	Example: Viper Insecticide Concentrate	Example: every weekday	Example: I sprayed it using a pump sprayer.	Example: I used the pesticide in my job as an exterminator.

**VIII. DAMAGES CLAIMS**

A. If you are claiming loss of income due to injuries allegedly caused by Roundup® or other glyphosate-based herbicides, complete the following for each of your employers, starting ten (10) years prior to your first diagnosis with cancer (whether NHL or another type of cancer) and continuing through today.

<b>Employer</b>	<b>Location (City and State)</b>	<b>Hours per Week</b>	<b>Day or Night Shift</b>	<b>Approximate Dates of Employment</b>	<b>How much money did you make in this job per week? Please specify how much was due to overtime pay or bonuses.</b>

B. State the total amount of time that you have lost from work as a result of any medical condition that you claim was caused by Roundup<sup>®</sup> or other Monsanto glyphosate-based herbicides, and the amount of income that you lost:

1. Medical Condition: \_\_\_\_\_
2. Total number of days lost from work due to above medical condition or if forced retirement, date of retirement:  
\_\_\_\_\_ days
3. Estimated total income lost (to date) from missed work, including explanation as to method used to calculate number:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Have you paid or incurred any out-of-pocket medical expenses (that is, expenses not paid by your insurance company or by a government health program) related to any condition that you claim or believe was caused by Roundup<sup>®</sup> or other Monsanto glyphosate-based products for which you seek recovery in this lawsuit?

Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes**, please state the total amount of such expenses at this time: \$ \_\_\_\_\_

D. If you are making any claims for other non-medical out-of-pocket expenses, please complete the following:

1. For what? \_\_\_\_\_
2. Amount of fees or expenses: \$ \_\_\_\_\_

E. Please list the names of all insurers or government health programs who have been billed for or paid medical expenses related to any condition that you claim or believe was caused by Roundup<sup>®</sup> or other Monsanto glyphosate-based products for which you seek recovery in this lawsuit.

---

---

---

**IX. DOCUMENTS**

Please attach the following documents to this Fact Sheet, making certain that all releases are signed and dated within **30** days of submission:

- A. Medical records release (Ex. A)—execute one per healthcare provider (including mental health, only if you are claiming mental health damages, including emotional distress, in the lawsuit). Plaintiffs’ counsel will also obtain 10 blank forms covering past 25 years, and if Monsanto identifies additional health care providers not identified in the PFS or on Exhibit A, Plaintiff will fill in that health care provider and provide to Monsanto within seven days of the request.
- B. Employment history release (Ex. B)—execute one for each employer in past 25 years.
- C. Workers' compensation, social security disability, and insurance claims releases (Ex. C).
- D. Tax records and social security income release for the past 10 years (Ex. D).
- E. If applicable, decedent's death certificate.

**DECLARATION**

I declare under penalty of perjury that all of the information provided in this Plaintiff’s Fact Sheet is true and correct to the best of my knowledge, information and belief, and that I have supplied all the documents requested in Part IX of this Declaration, to the extent that such documents are in my possession, custody, or control, or in the possession of my lawyers.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Printed)