UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

IN RE: NATIONAL HOCKEY LEAGUE PLAYERS' CONCUSSION INJURY LITIGATION	)	**MDL No. 14-2551 (SRN/JSM)**
This Document Relates to: ALL ACTIONS	)	**PRETRIAL ORDER NO. 15** Fact Sheets

1. This Order governs the form and schedule for the Plaintiff's Fact Sheet ("PFS") and Limited Authorization to Disclose Health Information ("Authorization") to be completed by all named plaintiffs in all cases filed in or transferred to this MDL proceeding.

2. This Order applies to plaintiffs in: (a) all cases transferred to this Court by the Judicial Panel on Multi-District Litigation pursuant to its Order of August 19, 2014; (b) all cases subsequently transferred to this Court by the Judicial Panel on Multi-District Litigation pursuant to Rule 7.4 of the Rules of Procedure of that Panel; and (c) all cases originally filed in this Court or transferred or removed to this Court that become part of this MDL proceeding. This Order does not apply to the six plaintiffs listed on Plaintiffs' Master Administrative Long-Form And Class Action Complaint.

Plaintiff Fact Sheets

3. Each plaintiff to whom this Order applies shall serve upon the NHL's counsel designated below a completed and signed PFS (using the form attached as Exhibit A) and a completed and signed Authorization (using the form attached as Exhibit

B), in accordance with the schedule ordered in paragraph 5 below. Each completed and signed PFS, Authorization and responsive documents shall be mailed or emailed to: John H. Beisner, Skadden, Arps, Slate, Meagher & Flom LLP, 1440 New York Avenue, NW, Washington, DC 20005, john.beisner@skadden.com.

4. The information contained in each PFS shall be verified by the responding plaintiff under oath. Plaintiffs' responses shall be treated as answers to interrogatories under Fed. R. Civ. P. 33 and requests for production of documents under Fed. R. Civ. P. 34. Each PFS and Authorization shall be signed and dated by the plaintiff or the proper plaintiff representative under penalty of perjury; however, they need not be notarized.

5. Each plaintiff whose case already has been filed in or transferred to this Court shall have 45 days from entry of this Order or the completion of service on the NHL, whichever is later, to serve upon the NHL a completed and signed PFS, a completed and signed Authorization. All documents responsive to the document requests contained therein shall be served within 75 days. When the NHL notifies the Judicial Panel on Multidistrict Litigation of additional cases for transfer to this Court, the NHL shall serve the plaintiffs in those cases with a copy of this Order. If and when any such case is transferred to this Court, each plaintiff shall have 45 days from the date of transfer or the completion of service on the NHL, whichever is later, to complete and serve upon the NHL a completed and signed PFS and a

completed and signed Authorization. All documents responsive to the document requests contained therein shall be served within 75 days.

6. Any Plaintiff who fails to comply with the PFS obligations imposed by this Order within the time periods set forth herein may be subject to having his claims, as well as any derivative claim(s), dismissed if good cause for such dismissal is shown. Good cause shall exist where the plaintiff (a) has failed to submit a PFS, or (b) where the plaintiff has failed to complete the PFS in all material respects, and the PFS thus contains a material deficiency and (c) the NHL establishes with the Court that it has exhausted all efforts to resolve the deficiency. Any dismissal may be with or without prejudice as the Court may determine in an individual case.

7. If a plaintiff fails to timely submit a PFS, or if the NHL receives a PFS in the allotted time but the PFS is alleged not to be complete in all material respects, the NHL's Lead Counsel shall send a deficiency letter by email and U.S. mail to plaintiffs' individual counsel allowing that plaintiff an additional 45 days to serve a PFS that is complete in all material respects.

8. The NHL's Lead Counsel shall send deficiency letters within 30 days of receipt of a PFS. Each deficiency letter shall be mailed or emailed to Liaison Counsel and plaintiff's individual counsel. The deficiency letter shall include a warning that the case is subject to dismissal under this Order if a PFS complete in all material respects is not received within 45 days of service of the warning. This letter should also include sufficient detail for the parties to meet and confer regarding

the alleged deficiencies. Should a plaintiff fail to cure the deficiencies identified and fail to provide responses that are substantially complete in all material respects within 45 days of service of the deficiency letter, the NHL is entitled to seek an Order to Show Cause why the case should not be dismissed. Any such filing shall be served on Liaison Counsel and plaintiff's individual counsel, with any response to such filing to be submitted within 15 days following the date of service. Any such motion should include the efforts the NHL made to meet and confer regarding the alleged deficiencies in the PFS.

9. Although the Court expects the parties to adhere to the deadlines set forth in this Order, the parties may agree to an extension of time for the service of a PFS, or for the cure of alleged PFS deficiencies, where good cause exists. Agreement to a good faith request for an extension shall not be unreasonably requested or withheld. If an extension request cannot be agreed upon, an application for relief may be made with the Court.

10. In the event that an institution or medical provider to whom any authorization is presented refuses to provide records in response to that authorization, the NHL shall notify the individual counsel for the plaintiff in question who shall obtain an executed authorization and return it within 30 days in whatever form is required by that institution or provider. Should a particular form be required, the NHL will provide it along with the notification to plaintiffs' individual counsel.

Defendant Fact Sheets

11. The parties shall meet and confer and agree on the scope and content of a Defendant Fact Sheet ("DFS") by June 4, 2015.

IT IS SO ORDERED.

ST. PAUL, MINNESOTA, this 1st day of June, 2015.

s/Susan Richard Nelson
SUSAN RICHARD NELSON
UNITED STATES DISTRICT JUDGE

EXHIBIT A

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

IN RE: NATIONAL HOCKEY LEAGUE PLAYERS' CONCUSSION INJURY LITIGATION	)	MDL No. 14-2551 (SRN/JSM)
This Document Relates to: ALL ACTIONS	)	

PLAINTIFF FACT SHEET

Please provide the following information for each named plaintiff in each case filed in or transferred to this MDL proceeding. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who currently or previously played in the National Hockey League ("NHL"). Whether you are completing this Plaintiff Fact Sheet for yourself or for someone else, please assume that "You" means the person who played in the NHL. In filling out this form please use the following definition: "Healthcare Provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, or other persons or entities involved in the diagnosis, care and/or treatment of you.

In filling out any section or sub-section of this form, please submit additional sheets as necessary to provide complete information. In addition, if you learn that any of your responses are incomplete or incorrect at any time, please supplement your responses to provide that information as soon as you become aware of it. This form requests information about your medical condition for a specified period of time. However, the NHL reserves the right to request additional information and information for a time period dating further back on a case-by-case basis, at which time the parties will meet and confer as the issue arises.

In completing this Plaintiff Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge, information and belief. If the response to any question is that the person completing this Plaintiff Fact Sheet does not know or does not recall the information requested, that response should be entered in the appropriate location(s). You may and should consult with your attorney if you have any questions regarding the completion of this form.

I. PERSONAL INFORMATION

1. Name (first, middle name or initial, last): _____

2. Other names used and dates during which you used those names:
_____

3. Current address and date when you began living at this address:
_____

4. Social Security Number: _____

5. Date and place of birth: _____

6. Current marital status: _____

7. Are you currently employed?

Yes _____ No _____

8. If yes, please list your current employer with name, address and telephone number, length of employment and your position there:
_____
_____

9. If not, did you leave your last job for a medical reason?

Yes _____ No _____

10. If yes, describe why you left:
_____

11. Have held any other jobs since your retirement from the NHL?

Yes _____ No _____

If yes, please provide the following information:

Employer	Approximate Dates of Employment	Nature of Job

12. Have you ever served in any branch of the military?

Yes _____ No _____

Branch(es) and date(s) of service:

_____

If yes, were you ever discharged for any reason relating to your medical or physical condition?

Yes _____ No _____

If yes, state what that condition was: _____

13. Have you ever been rejected from military service for any reason relating to your medical or physical condition?

Yes _____ No _____

If yes, state what that condition was: _____

14. If you have Medicare, please state your HICN number: _____

15. What is your current average alcohol intake?
Do not drink _____ Less than 1-2 drinks per day _____
1-2 drinks per day _____ 2-3 drinks per day _____
3-4 drinks per day _____ More than 4 drinks per day _____

If your historical alcohol consumption has varied from your present level, please provide the following information:

Date	Approximate Number of Drinks Per Day

16. Have you ever used illegal drugs or misused prescription drugs?

Yes _____ No _____

If yes, please provide the following information:

Name of Drug	Date of Use	Approximate Number of Times of Use

17. Have you participated in any hobbies since your retirement from the NHL?

Yes _____ No _____

If yes, please provide the following information:

Hobby	Approximate Dates of Participation

18. Have you played in any NHL or NHL alumni sponsored hockey games for charity since your retirement from the NHL?

Yes _____ No _____

If yes, please provide the following information:

Charity	Approximate Dates of Participation	Nature of Participation

19. In the last 15 years, have you ever subscribed to or regularly purchased any newspaper, magazine or other periodical?

Yes _____ No _____

If yes, please provide the following information:

Name of Publication	Approximate Subscription or Purchase Dates

II. HOCKEY CAREER

1. Please provide the following information regarding your playing career in any professional hockey league or amateur hockey league:

Date (starting and ending)	Team	State or Province of Residence

2. Have you ever participated in a fight during a game while playing professional hockey?

Yes _____ No _____

If yes, please provide the following information:

Date of Fight	Nature of Fight	Location of Fight (city, state/province, country)	Game Opponent (team)	Other Player(s) Involved	State or Province of Residence at Time of Fight

3. Have you ever sustained an injury during a hockey game resulting from your head hitting the boards, ice and/or glass?

Yes _____ No _____

If yes, please provide the following information:

Date of Injury	**Nature of Injury**	**Location of Injury (city, state/province, country)**	**Game Opponent (team)**	**Other Player(s) Involved**	**State or Province of Residence at Time of Injury**

4. List all player agents and physical or athletic trainers you hired to advise you while playing professional hockey, including the last known address of each individual you identify:

_____
_____

5. Have you participated in any NHL- or NHL-alumni-sponsored fan events or similar hockey-related events since your retirement from the NHL?

Yes _____ No _____

If yes, please provide the following information:

Event	**Event Date**	**Role at Event (e.g., speaking, signing autographs, posing for photographs)**

III. HEAD INJURIES

1. Have you ever suffered a concussion or other head injury during a game or practice while playing hockey?

Yes _____ No _____

If yes, please provide the following information:

Date of Injury	Nature of Injury	Location of Injury (city, state/province, country)	Game Opponent (team)	Other Player(s) Involved	State or Province of Residence at Time of Injury

2. Have you ever suffered a concussion or other head injury during any non-hockey activity?

Yes _____ No _____

If yes, please provide the following information:

Date of Injury	Nature of Injury	Location of Injury (city, state/province, country)	State or Province of Residence at Time of Injury

3. Have you received medical treatment for any concussions and/or other head injuries identified in your responses to questions III.1-III.2, above?

Yes _____ No _____

If yes, please provide the following information:

Date of Treatment	Treating Healthcare Provider Name	Treating Healthcare Provider Address	State or Province of Residence at Time of Injury

4. Have you ever used any precautions to avoid concussions or head/brain injuries generally during your hockey career?

Yes _____ No _____

If yes, please provide the following information:

Type of Precaution	Approximate Dates You Used Precaution

5. Have you received any other treatment or testing related to your alleged injuries since filing suit?

Yes _____ No _____

If Yes, please state:

Date	Facility Name	Address and Telephone Number	Reason	Results

IV. YOUR CLAIMS IN THIS LAWSUIT

1. Describe how and when you first came to believe that you have any disease, condition, symptoms, or other injuries resulting from concussions or head/brain injuries:

_____
_____

2. Identify all specific disease(s), illness(es), or medical condition(s) that you attribute to your participation in hockey in the NHL for which you are seeking damages or other relief in this lawsuit:

_____
_____

3. Are you currently experiencing any symptoms that you believe are precursors to Alzheimer's disease, dementia, and chronic traumatic encephalopathy ("CTE")? If so, what are they?

_____
_____

4. Before hiring your lawyer, did you have any communications with current or former NHL players about the consequences or effects of concussions or head injuries sustained while playing hockey in the NHL?

Yes _____ No _____

If yes, please provide the following information and attach copies of any documents in your possession regarding any such meeting or communication:

Date	Location	Other Player(s) Involved	Nature of Meeting or Communication

5. Before hiring your lawyer, did you receive any communications about the consequences or effects of concussions or head injuries sustained while playing hockey in the NHL?

Yes _____ No _____

If yes, please provide the following information and attach copies of any documents in your possession regarding any such meeting or communication:

Date	Location	Other Player(s) Involved	Nature of Meeting or Communication

6. Before hiring your lawyer, did you attend any meetings or seminars regarding the consequences or effects of concussions or head injuries sustained while playing hockey in the NHL?

Yes _____ No _____

If yes, please provide the following information and attach copies of any documents in your possession regarding any such meetings or seminars:

Date	Location	Other Player(s) Involved	Nature of Meeting

V. OTHER MEDICAL INFORMATION

1. Have you had health insurance or a health insurance carrier that has provided you with medical coverage and/or pharmacy benefits at any time from your fifteenth birthday to the present while playing hockey?

Yes _____ No _____

If yes, please provide the following information:

Name of Insurance Company	Name of Insured	Named Insured's Social Security Number	Policy Number

2. Other Conditions

a. To the best of your knowledge, have you ever experienced or been diagnosed with any of the following conditions from your fifteenth birthday to the present? Please mark Yes or No for each condition. For each condition for which you answer Yes, please provide the additional information requested in the table following this chart:

Condition Experienced or Diagnosed	Yes	No	Don't Know
1. Parkinson's Disease			
2. Neuropathy			
3. Cancer			
4. Diabetes			
5. Tumors			
6. Autoimmune diseases			
7. Alcohol or drug addiction			
8. Psychiatric issues			
9. Orthopaedic issues			

b. For each condition for which you answered yes in the previous chart, please provide the information requested below:

Condition You Experienced	Approximate Date of Onset	Name, Address and Telephone Number of Treating Physician (if any)	Treatment Received

3. Have any of your parents and/or siblings been diagnosed with a chronic physical or mental condition or illness?

Yes _____ No _____

If yes, please provide the following information:

Name of Relative	Relationship to You	Diagnosed Condition(s)

VI. LEGAL PROCEEDINGS

1. For the period from the time from your fifteenth birthday to the present, or at any time if it involved an injury or condition with your head, have you applied for or received workers' compensation, Social Security, and/or state or federal disability benefits?

   Yes _____ No _____

   If yes, then as to each application, separately state the following and attach any documents you have which relate to the application and/or award of benefits:

   a. Date (or year) of application: _____

   b. Type of benefits: _____

   c. Nature of claimed injury/disability: _____

   d. Period of disability: _____

   e. Amount awarded: _____

   f. Basis of your claim: _____

   g. Was claim denied?

      Yes _____ No _____

   h. To what agency or company did you submit your application: _____

      _____

   i. Claim/docket number, if applicable:_____

2. List all other actions in which you have ever sought, successfully or unsuccessfully, to serve as a class representative:

_____
_____

VII. HEALTHCARE PROVIDERS

1. List each doctor or Healthcare Provider (including, but not limited to, family/primary care physicians, orthopedic surgeons, physical therapists, chiropractors and practitioners of the healing arts) whom you have seen for medical care and treatment from your fifteenth birthday to the present.

Name and Specialty	Address and Telephone Number	Approximate Dates/Years of Visits	Reason

2. List each hospital, clinic, surgery center, healthcare facility, physical therapy or rehabilitation centers where you have received medical treatment (in-patient, out-patient, or emergency room visit) from your fifteenth birthday to the present.

Name	Address	Admission Date(s) (if applicable)	Reason	Type of Surgery (if applicable)	Name of Surgeon (if applicable)

3. List each facility at which radiographs (x-rays, ultrasounds, MRIs, CT scans) were taken of your head from your fifteenth birthday to the present.

Name	Address and Telephone Number	Approximate Date Taken	Reason

4. List each pharmacy, drugstore or any other facility or supplier (including, but not limited to, mail order pharmacies) where you ever received any prescription medication from your fifteenth birthday to the present.

Name of Pharmacy/Supplier	Address and Telephone Number of Pharmacy/Supplier	Approximate Dates/Years You Used Pharmacy/Supplier

VIII. MEDICATIONS

1. List all of the medications (prescription and over the counter) you currently take.

Medication	Dose/ Frequency/Dates of Use	Physician Ordering	Pharmacy Dispensing	Purpose

2. Are there any prescription medications other than those identified that you have taken on a regular basis for any duration of more than two months from your fifteenth birthday to the present?

Yes _____ No _____

If yes, please List the medication(s), the doctor(s) who prescribed it, the approximate dates/years you have taken this medication, and why it was given to you:

Medication	**Dose/ Frequency/ Date(s) of Use**	**Physician Ordering**	**Pharmacy Dispensing**	**Purpose**

IX. INJURIES & DAMAGES

1. Are you making a claim for lost wages or lost earning capacity?

Yes _____ No _____

If yes, describe your claim. Your description should include the total amount of time (and amount of income) which you have lost or will lose from work as a result of any

condition that you claim or believe was caused by your career in the NHL, and an explanation of how those amounts were calculated:

_____

_____

_____

_____

2. State the amount of medical expenses, by provider, which you have incurred, including amounts billed to insurers and other third-party payors, for which you seek recovery in this lawsuit:

Name and Address of Provider	Dates of Treatment	Amount of Medical Expenses
		$
		$
		$
		$
		$

For any expenses claimed above, have they been reimbursed or reduced by any third party?

Yes _____ No _____

3. Has your present or former spouse filed a loss of consortium or other claim in this action?

Yes _____ No _____

X. AUTHORIZATION

Complete and sign the attached Authorization.

XI. VERIFICATION

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

Date: _____ _____

Signature

EXHIBIT B

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO:
Patient Name:
DOB:
SSN:

I, _____, hereby authorize you to release and furnish to: Skadden, Arps, Slate, Meagher & Flom and/or its designee copies of the following information:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctors' handwritten notes, and records received by other physicians, dated from my 15th birthday to the present.

* All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports, dated from my 15th birthday to the present.

* All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos, dated from my 15th birthday to the present.

* All pharmacy/prescription records, including NDC numbers and drug information handouts/monographs, dated from my 15th birthday to the present.

* All billing records including all statements, itemized bills, and insurance records, dated from my 15th birthday to the present.

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendant for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**

2. I understand that the information in my health record may include information relating to information about behavioral or mental health services and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicate above.

5. A notarized signature is not required. C.F.R. 164.508. A copy of this authorization may be used in place of an original.

Print Name:_____ (plaintiff/representative)

Signature:_____ Date:_____