Physician's Declaration

In completing this form, you may consider the patient's medical records, charts, reports, diagnostic films, medical history, or other sources of information that physicians regularly and routinely rely upon in their practice. By signing this form, you certify that all opinions set forth below are offered to a reasonable degree of medical probability. In other words, by signing this form you certify that you are of the opinion that the conclusions set out in this form have a probability greater, but not significantly higher, than 50%.

1. PHYSICIAN BACKGROUND

_____ _____ _____
(First Name) (Middle Initial) (Last Name)

_____
(Office Address)

_____ _____ _____
(City) (Province) (Postal Code)

_____
(Area Code & Telephone Number)

Check whether you are a/an:

□ Orthopedic surgeon

□ General Practitioner

□ Other _____

College of Physicians and Surgeons Registration Number: _____

2. PATIENT INFORMATION

State the name and birth date of the patient for whom you are providing the information contained in this Physician Declaration Form.

_____ _____ _____
(First Name) (Middle Initial) (Last Name)

_____
(Birth Date MM/DD/YYYY)

Are you one of the patient's treating physicians?

□ Yes □ No

If "Yes,", state your role in the patient's medical care and treatment relative to their M2a 38, M2a Magnum or ReCap Femoral Resurfacing System metal-on-metal implant:

_____

_____

3. IMPLANT INFORMATION

State the reference and catalogue numbers that correspond to the patient's M2a 38, M2a Magnum or ReCap Femoral Resurfacing System Metal-on-Metal Implant(s).

Date of Implantation (Right) _____
(MM/DD/YYYY)

Implant Reference/Catalogue Numbers _____
(if available)

Implant Lot Number _____
(if available)

Date of Implantation (Left) _____
(DD/MM/YYYY)

Implant Reference/ Catalogue Numbers _____
(if available)

4. REVISED PATIENT OR PATIENT INDICATED OR SCHEDULED FOR REVISION

Has the patient been indicated for a revision surgery to replace the M2a 38, M2a Magnum or ReCap Femoral Resurfacing System?

□ Yes □ No

If "Yes," please answer the remaining questions in section 4. If "No," please skip to section 7.

Date of the indication: _____
(DD/MM /YYYY)

Has a revision surgery been scheduled? □ Yes □ No

If "Yes," date/time on which the surgery is scheduled: _____
(DD/MM /YYYY)

If "No," do you certify that the revision surgery is planned, even if the date and time have not yet been finalized? □ Yes □ No

If the revision surgery has been scheduled, has the surgery occurred? □ Yes □ No

If "Yes," date on which the revision surgery took place: _____
(DD/MM/YYYY)

Describe all reason(s) a revision surgery for the M2a 38, M2a Magnum or ReCap Femoral Resurfacing System was indicated and identify all testing or films taken and the results that support this diagnosis:

_____

_____

_____

5. UNREVISED PATIENT WHERE REVISION SURGERY IS PRECLUDED

If a revision surgery has not been scheduled or will not take place, is there a medical condition that prevents the patient from undergoing a revision surgery ("Precluded" / "Preclusions")? □ Yes □ No

If "Yes," describe the Preclusion(s) that prevent(s) replacement of the M2a 38, M2a Magnum or ReCap Femoral Resurfacing System, and state whether the Preclusion(s) is/are temporary or permanent:

_____

_____

_____

Provide the date on which you determined that a revision surgery for the patient was Precluded: _____

(DD/MM/YYYY)

6. COMPLICATIONS RESULTING FROM REVISION SURGERY

□ Check here if the patient underwent a revision surgery or surgeries to remove their M2a 38, M2a Magnum or ReCap Femoral Resurfacing System implants.

If you checked the box above, and the patient sustained any of the following complications during or after their revision surgery, please state the date(s) on which the complication(s) occurred:

Complication	Date(s)
Infection (any infection in the revised hip that is diagnosed within 30 days after a Revision Surgery and determined to have been caused by the Revision Surgery)	
Permanent Nerve Damage (nerve damage [including but not limited to meralgia paresthetica and foot drop caused by peroneal nerve damage] resulting from a Revision Surgery that is permanent as established by medical records or a Physician's Declaration, or that has persisted for 18 months or more)	
Second Revision (surgery to remove a replacement hip implant that had been implanted as part of a Revision Surgery because the replacement hip device failed)	
Blood Clot (diagnosis made within 72 hours of a Revision Surgery of pulmonary embolism or deep vein thrombosis that resulted from a Revision Surgery)	
Stroke (cerebrovascular incident or insult occurring within 72 hours of a Revision Surgery and determined to have been caused by the Revision Surgery)	
Third Revision (surgery to remove a replacement hip implant that had been implanted as part of a Second Revision because the replacement hip device failed)	
Death (class member died within 72 hours after a Revision Surgery as a result of the Revision Surgery)	

Femoral Fracture (fracture of femur that occurs during a Revision Surgery or as a result of the Revision Surgery, and does not include fracture that results from trauma that occurs before or after the Revision Surgery)	
Dislocation (complete disassociation of femoral head and acetabular cup that occurs within 6 weeks of the Revision Surgery)	
Lost Wages (economic loss supported by documentary evidence showing income loss in excess of 20% of the claimant's aggregate gross income for the two highest earning years in the four years preceding the Revision Surgery)	
Heart Attack (myocardial infarction or cardiac arrest occurring within 72 hours of a Revision Surgery and determined to have been caused by the Revision Surgery)	

Please attach medical records to this form that confirm that the complication(s) noted above occurred. Such medical records may include, but are not limited to, operative reports, pathology reports, office records, and/or discharge summaries.

7. DECLARATION

I affirm that the foregoing representations are true and correct.

Executed on _____, 20____.

By: _____

Signature of Physician

_____

Print Name