
██████████
vs.

AMEX PROPERTY CASUALTY AND FORD MOTOR COMPANY

SETTLEMENT BROCHURE

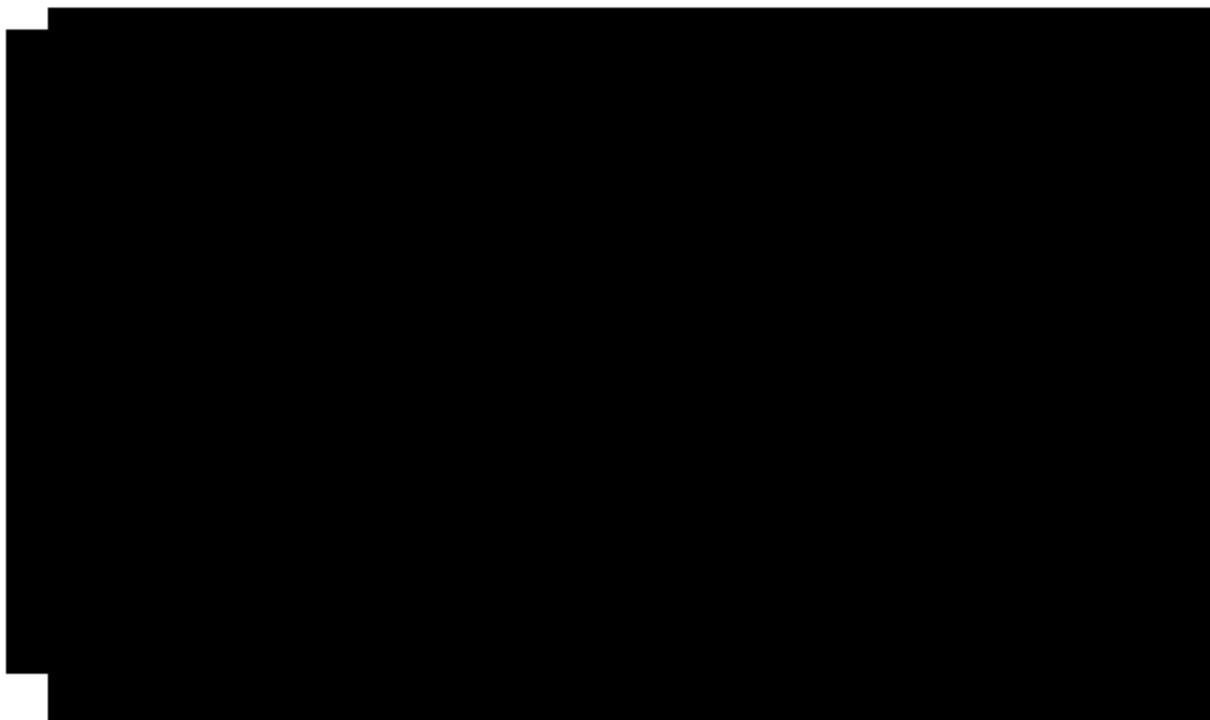
Dated: March 23, 1998

Veronica Casey amv
VERONICA CASEY (#136098)
Attorney for Plaintiff
VERONICA CASEY LAW OFFICE, LTD.
701 Fourth Avenue South
Suite 500
Minneapolis MN 55145
(612) 337-9526

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Veronica Casey, Attorney at Law

Ann Speltz - Vrs. Legal Assistant
Barbara Jelich, Legal Assistant
Candela Kubitschek, Legal Assistant

March 23, 1998

Ms. Lisa Langenberg
AMEX Property Casualty
1400 Lombardi Avenue
Green Bay, WI 54304-3922

Re: Our Client: [REDACTED]
Your Insured: [REDACTED] (UM)
Our File No: 4391
Your Claim No.: [REDACTED]
Date of Loss: 11-6-96

Mr. Jessie Hollingsworth
Ford Motor Company
400 Parklane Towers West
Three Parklane Blvd.
Dearborn, MI 48126-2568

Re: Our Client: [REDACTED]
Your Insured: Ford Motor Company
Our File No: 4391
Your Claim No. Unknown
Date of Loss: 11-6-96

Dear [REDACTED]

Included here is the Settlement Brochure in the above-referenced matter. The Index for documentation in this matter is contained in the INDEX portion of the Brochure. For your convenience, a courtesy copy of this letter is included in Exhibit 1.

As you know, this was a hit-and-run accident and is an uninsured motorist claim. This accident occurred on November 6, 1996, at approximately 10:00 p.m. [REDACTED] was driving southbound on [REDACTED] toward the intersection of [REDACTED]. As she drove through the intersection she was suddenly struck by a speeding car in the rear panel of her car. The other car did not have its lights on. Her car spun around and she was turned facing the opposite direction. The male driver of the other vehicle asked her if she was alright, but before she could really answer, he got back into his car and left the accident scene. Unfortunately, [REDACTED] and an eyewitness to the accident were unable to obtain a license plate number.

Ms. Lisa Langenberg
Mr. Jessie Hollingsworth
March 23, 1998
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The following week, [REDACTED]

[REDACTED]

Exhibit 5.

[REDACTED]

Exhibit 5.

[REDACTED] had a very difficult time coping with her acute pain. At the time of this accident, [REDACTED]

[REDACTED]

Prior to this accident, [REDACTED] was in good health. [REDACTED]

[REDACTED]

Exhibit 7.

Ms. Lisa Langenberg
Mr. Jessie Hollingsworth
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Also, In September and October, 1996.

Her pain was bothersome but was not debilitating. She was not in acute distress and was able to move without hesitation.

Exhibit 8.

Ms. Lisa Langenberg
Mr. Jessie Hollingsworth
March 23, 1998
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[REDACTED]

[REDACTED] continues to struggle every day to cope with her pain. Had this accident not occurred, she would have completed her [REDACTED] and been well on her way to [REDACTED]

[REDACTED]

[REDACTED] has incurred \$4,497.27 in medical expenses which have been paid by her no-fault insurance carrier, American Express Property Casualty Company. The PIP Payment Ledger is attached as Exhibit 10.

It is the opinion of [REDACTED] has sustained a permanent [REDACTED] as a result of this accident. He recommends an aggressive [REDACTED] to help control [REDACTED]. He believes [REDACTED]

[REDACTED] although this is not totally certain. The permanency report of [REDACTED] is attached as Exhibit 11.

[REDACTED] makes her demand to settle this case at this time for \$40,000.00, 1/2 from AMEX Insurance Company and 1/2 from Ford Motor Company if the matter can be resolved in the near future. Please call me within 10 days of the receipt of this letter to avoid the service of a Summons and Complaint.

Sincerely,

Veronica Casey
Veronica Casey
VC/pk

cc: [REDACTED]

TRAFFIC ACCIDENT REPORT

06-348199 NOV 8 1999 POLICE USE ONLY AS REQUIRED BY STAT PAGE 1 OF 1

VEHICLE 1: N 2 0 1 4 H & R 11 06 96 N 22 00

VEHICLE 2: 37th Ave S 53rd St E

CITY: Mpls

DRIVER 1: UNKNOWN

DRIVER 2: UNKNOWN

VEHICLE 1: Olds Cutlass

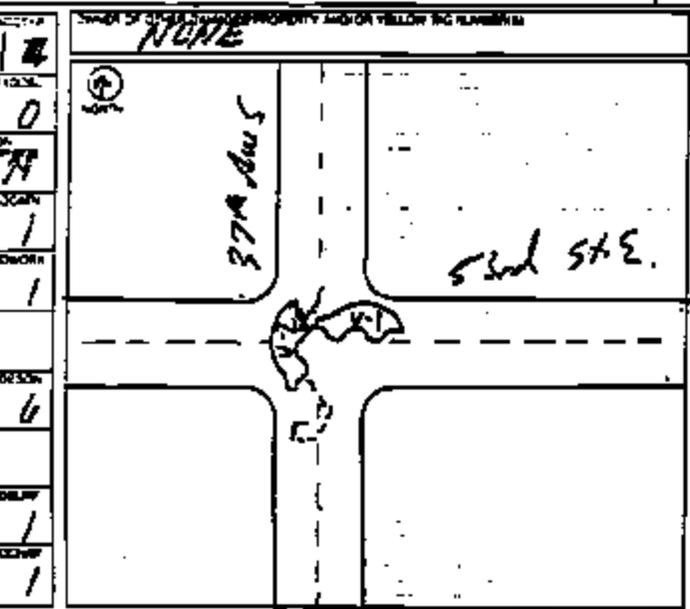
VEHICLE 2: Ford Probe

VEHICLE 1: UNKNOWN

VEHICLE 2: Ford Probe

INSURANCE: F 4 3 C N

NAME	POSSIBLE WITNESS?	LINE	POSS	AGE	SEX	HAIR	HEIGHT	WEIGHT	PLACES	TO HOOP	TRANSPORT
[Redacted]											
[Redacted]											

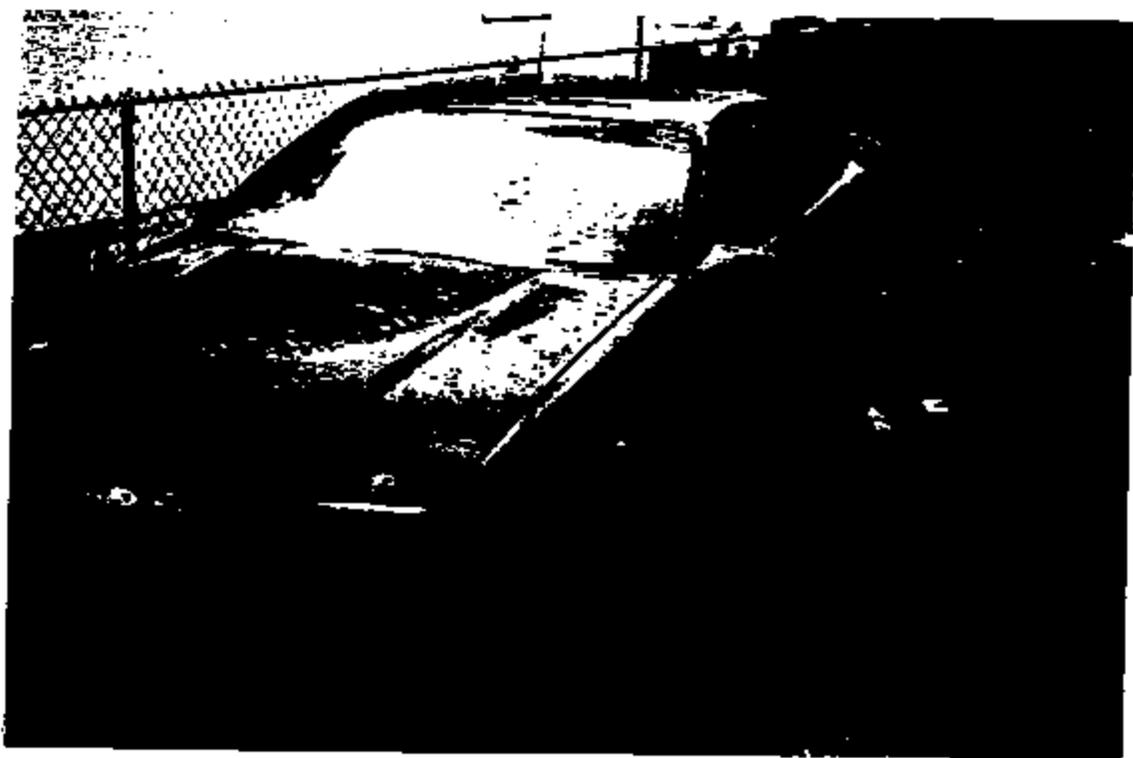


AMBULANCE SERVICES: RIC MC Paramedics #54507

DESCRIPTION OF ACCIDENT: V-2 was travelling SB on 37th Ave S, when, while in the intersection with 53rd St E., V-1 struck V-2 in the left rear panel of V-2. V-2 spun in a 360° circle and stopped. Driver of V-1 asked V-2 if she was alright, then driver of V-1 left scene WB on 53rd. Witness was unable to get plate of V-1. Intersection is uncontrolled, V-2 was in intersection when hit by V-1 entering intersection.

OFF. Wente #7040 / OFF. Freundschuh #2110 MPD

REPORTING OFFICER: [Redacted]





SEX: M SINGLE DOB: [REDACTED]
RACE: SSS REL: [REDACTED]
PREV AD 08/23/95
MINNEAPOLIS, MN COUNTY: HENNEPIN PREV DIS: 9/24/88
EMPL: NOT EMPLOYED NONE
H-PH: [REDACTED]
U-PH: [REDACTED] MN,

DOC: 99999 MED, CLINIC CNS DOC

OP TYPE: EMRGY OF SERV: ER INFO YES SHOW YES PT TYPE: E PT CLASS

CHIEF COMPLAINT: HVC, NECK AND BACK STIFFNESS WITH KNEE PAIN 10

GUAR: [REDACTED] REL: PATIENT SSS [REDACTED]
EMPL: NOT EMPLOYED, NONE
MINNEAPOLIS, MN, [REDACTED] MR,
H-PH: [REDACTED] U-PH: [REDACTED]

EMERGENCY CONTACT: [REDACTED] REL: MOTHER
U-PH: [REDACTED]
NEAREST RELATIVE: [REDACTED] REL: FRIEND
H-PH: [REDACTED] U-PH: [REDACTED]

SPOUSE NAME: SPOUSE EMPL:

INITIAL CLASS: 9
INS: 44 REF DT: EXP DT:
POLICY #: POL. HLDG: POL. HLDG: SSS:
EMP/GRP: COMMENTS:
CENTIF: 6:

INS: 44 REF DT: EXP DT:
POL. HLDG: SSS: POL. HLDG: SSS:
EMP/GRP: COMMENTS:
CENTIF: 6:

REF: 999 MED, CLINIC

MN 612-000-0000 MINNEAPOLIS, MN 612-000-0000
POL INFO: CR: 2 NO FAULT DT/TH: 7/02/95 LCC: [REDACTED]
RESID: WORK INJ: EEMPL: [REDACTED]
AMBULANCE: NO AMBULANCE NAME: MEDICARE: X ANN: N
CURRENT ST CURRENT MED COND

Assembled
[Signature]
Coded
Cleared

[REDACTED]

Minneapolis, MN [REDACTED]

NAME: [REDACTED]
MR#: [REDACTED]
DATE: 11/07/96

PHYSICAL EXAMINATION (continued)

NEUROLOGIC: Normal with good hand grasps.

[REDACTED]

DIFFERENTIAL DIAGNOSIS

[REDACTED]

[REDACTED]

[REDACTED]

DIAGNOSTIC IMPRESSION

1. [REDACTED]
2. [REDACTED]
3. [REDACTED]
4. [REDACTED]

PLAN

1. [REDACTED]
2. [REDACTED]
3. [REDACTED]
4. [REDACTED]

[REDACTED]

Minneapolis, MN

NAME: [REDACTED]

MR#: [REDACTED]

DATE: 11/07/96

- 5. Return to the Emergency Department for increasing problems, otherwise follow up with the Medicine Clinic where she is a patient for any continued concerns.

David Peterson, M.D.



DP/JB

D: 11/07/96

T: 11/12/96

R#: 30043

CHART

PMD: _____ WORKER COMP.
DOB: _____ OCC. HEALTH
SEX: F NAME _____

SOCIAL SECURITY #: _____ ACCOMPANIED BY: _____

Arrival Mode Ambulance Walk WC Arrival Time _____ Triage Time _____ ET Bed # _____ Time 0711 Level 1 2
 Carry Cart From _____ FT _____

What Signs _____ Chief Complaint _____
T _____
P _____
R _____
BP _____

Allergies _____ Meds/Dosage/Frequency _____

Health History Td _____ LMP _____

Body System Respiratory Cardiovascular Neuro ENT Eye GI GU Behavioral Crisis Skin
 Reproductive Musculoskeletal Communicable Disease Considerations Infection Control Concerns Non-specific Dental

Subjective History Time: 0054 pt in MVC \approx 2200 tonight was
lap belted driver, was hit by another
car on back of drivers side + spun around.
police notified, etc.

Objective Findings Time: _____

Cognitive Assessment
Indicate variances and document plan of care.
 Pain D-10 _____
 Sensory deficit
 Knowledge deficit
 Impaired verbal communication

SocioCultural Assessment
Indicate variances and document plan of care.
 Unable to care for self Language barriers
 Lack of support system Unable to work
 Cultural preferences

Spiritual Assessment
Indicate variances and document plan of care.
 Fear Anxiety
 Depression Grieving
 Spiritual distress Living Will
 Ineffective coping

WDL
• Support system evident
• English speaking or interpreter present
• Activities of daily living not affected
• Employment _____

WDL
• Verbalize no spiritual concerns
• Emotional response appears proportionate to physical assessment

WDL
• Verbalize no spiritual concerns
• Emotional response appears proportionate to physical assessment

Wound Diagnosis
 Activity intolerance
 Anxiety
 Cardiac output, altered
 Coping, ineffective
 Fear
 Fluid volume excess

Grieving
 Infection, potential for
 Injury, potential for
 Knowledge deficit
 Metic behavior
 Mobility, impaired physical
 Nutrition, alteration in

Spiritual distress
 Thought process, alteration
 Tissue perfusion, alteration
 Urinary elimination, alteration in pattern
 Violence, potential for

LAB Io _____

Visual Acuity
R _____ L _____ Correct
Time _____ Correct

Time: _____
LA RA _____
BP _____
HR _____

Time: _____
LA RA _____
BP _____
HR _____

Supporting Documentation
Mental Health
Consents

[REDACTED]

MEDICAL RECORDS

MPLS, MN [REDACTED]

[REDACTED]

NAME [REDACTED]
DOS 11/07/96 REQ NO [REDACTED]
READ 11/07/96 TYPED 11/07/96 08:10
RADIOLOGIST SIRR, STEVE

PAT ID [REDACTED] DOB [REDACTED]
REFERRED BY [REDACTED]
TYPED BY 33 LOCATION EMRG
CONSULT RAD

PRELIMINARY REPORT

[REDACTED]

##

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

MPLS, MN [REDACTED]

MEDICAL RECORDS

[REDACTED]

NAME [REDACTED]
DOS 11/07/96 REQ NO [REDACTED]
READ 11/07/96 TYPED 11/07/96 10:49
[REDACTED]

PAT ID [REDACTED] DOB [REDACTED]
REFERRED BY UNKNOWN, DR
TYPED BY 53 LOCATION EMRG
CONSULT RAD

[REDACTED]

[REDACTED]

PAGE 1

[REDACTED]

[REDACTED]

MPLS, MN [REDACTED]

MEDICAL RECORDS

[REDACTED]

[REDACTED]
DOS 11/07/96 REQ NO [REDACTED]
READ 11/07/96 TYPED 11/07/96 11:37
[REDACTED]

PAT ID [REDACTED] DOB [REDACTED]
REFERRED BY UNKNOWN, DR
TYPED BY 27 LOCATION EMRG
CONSULT RAD

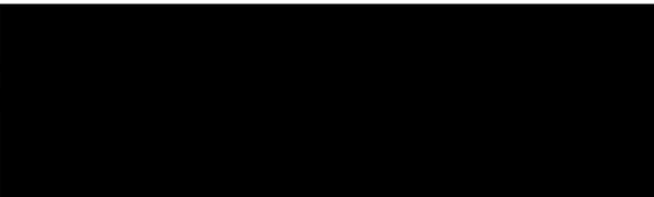
[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

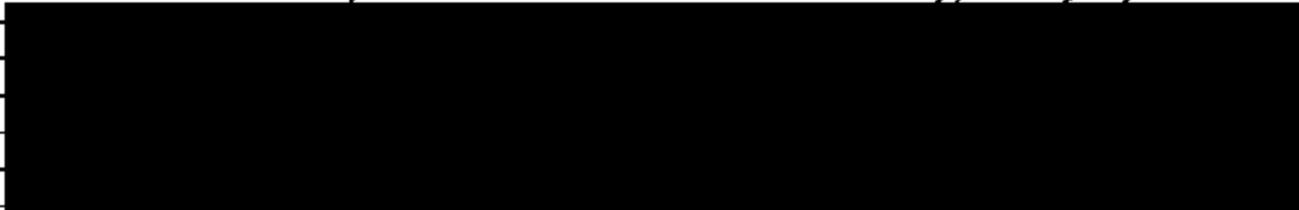
11/07/96 11:37 AM



Mississippi, Missouri
Phone

INSTRUCTIONS

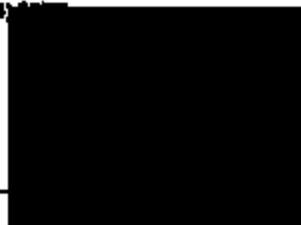
Follow up at Medical Center for cont. problems



Your blood pressure today was _____ Diphtheria / Tetanus booster given today.

INSTRUCTION SHEET(S)

- Abd. Pain
- Back Care
- Burn Care
- Chest Care
- Diarrhea



- Kidney Stone
- Lice
- Medications which Affect Mood
- Nose Bleed

- Sprains
- Tet. Vaccing Information Packet
- URI
- UTI

- Vac. Carriage
- Vag. Std / Preg.
- Vaginal Infection
- V.D.
- Wound Care

REFERRED TO:

Phone # _____

- Private Physician
- Other _____

- When calling for an appointment, please inform the physician's office you were referred by the Emergency Department.
- Call today tomorrow Monday for appointment in _____ days weeks.
- If no improvement in _____ hours days, call your private physician or physician / clinic you have been referred to for an appointment.
- If your condition worsens, call your private physician or return to the Emergency Department.
- X-RAY: During your visit to the Emergency Department, x-rays were taken and provisionally read. The final reading will be done by a Board Certified Radiologist and a report will be sent to your private physician. If you have any questions or concerns relevant to your x-rays, please contact your family physician.

I understand that the treatment I have received was rendered on an emergency basis only and is NOT meant to take the place of complete care from a personal physician or clinic. If my condition worsens, I have been instructed to call my family physician or return to Abbott Northwestern Emergency Department. I have read and understood the above and checked a copy of this form and applicable instruction sheets and I will arrange for follow-up care.

Instructed By _____

WORK / SCHOOL STATEMENT from Abbott Northwestern Emergency Department

- Patient was seen by Dr. _____
- May return to work / school WITHOUT restrictions.
- Will require time off work / school. Estimated time _____ days.
- May return to RESTRICTED duties for _____ days.

Restrictions _____

- Must be re-evaluated by physician / Occupational Health before returning to work / school.
- Other _____

Signature RN / MD _____

PITAL

AUTHORIZATION TO RELEASE INFORMATION

I authorize this health care facility to release all medical information, including psychiatric/mental health, chemical dependency and/or AIDS related information to my HMO, insurance company, third party payor, or their designee, as may be necessary for the payment of my bill, determining benefits, or for utilization and quality review purposes for this episode of care.

I further authorize the release of this information to other health care agencies, professionals or persons, who may provide health care services deemed necessary for continuing my medical care.

CONSENT FOR TREATMENT

I authorize the performance of the diagnostic tests, procedures and treatments, and/or the administration of the medications which may be deemed appropriate by the physician, surgeon or other personnel involved in my care. I understand that persons receiving medical training may be involved in my care. I understand that most physicians are not employees or agents of this health care facility, but are independent contractors who have been granted privileges to treat patients in this health care facility. This consent for treatment includes the services which these physicians may perform as well.

I further understand and acknowledge that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me about the results of the examination and/or treatment to be provided in this health care facility.

HEALTH CARE FACILITY'S LIABILITY FOR PERSONAL PROPERTY

I understand and agree that this health care facility will not be responsible or liable for loss or damage to any money, jewelry, or other personal property or articles which are worn by the patient or kept in the patient's room or unit. This health care facility will assume responsibility only for those valuables delivered to health care facility personnel for storage in the facility's safe which delivery is reflected in a receipt provided to the patient.

ASSIGNMENT OF BENEFITS

I assign to the health care facility all benefits payable to me for this care. I understand that the health care facility will be paid directly by the insurance company or other payor.

GUARANTEE OF ACCOUNT

I guarantee payment of all charges incurred for treatment and/or confinement of the patient in accordance with the rates and terms of this health care facility.

Signature of Patient or Representative Party

Relationship to Patient

Reason Patient is Unable to Sign

AUTHORIZATION / CONSENT FORM

RECEIVED FILE # 14 1997

8/18/59

118-96

MINNEAPOLIS MN

12/11/85

Phone Contact

MEDICA

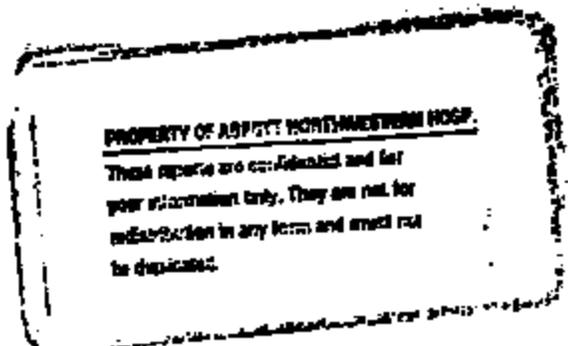
Major Medical Problems

[Redacted]

Drugs

✓ d B

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Allergies

Nursing Problems

Nursing Care Focus

[Redacted]

Social Work

[Redacted]

CC/Problem

[Redacted]

HISTORY

[Large redacted area]

REVIEW OF SYSTEMS

Check if reviewed and negative:

Notes/positives

Notes/Positives

- General/Metabolic
- Skin/Hair/Nails
- Hematologic/Immunologic
- Bones/Joints
- Neuromuscular/Psychiatric
- Eyes
- Ears
- Nose/Sinuses

- Mouth/Throat
- Breasts
- Respiratory
- Cardiovascular
- Gastrointestinal
- Urinary
- Reproductive

PERMANENT HEALTH SHEET REVIEWED

PHYSICAL EXAM (Check if negative, comment on positives and pertinent negatives)

TEMP = _____

WEIGHT = _____

- Skin
- Hair/Nails
- Nodes
- Bones/Joints
- Neuromuscular
- Head
- Eyes

- Ears
- Nose/Mouth/Thr.
- Neck
- Breasts
- Respiratory
- Cardiovascular
- Abdomen
- Genitalia

LAB:

ASSESSMENT

PLAN

RTG _____ instructions: written _____ verbal _____
RN: _____

RESIDE

STAFF

REVIEW OF SYSTEMS

Check if reviewed and negative:

Notes/positives

Notes/Positives

[Redacted]

[Redacted]

Mouth/Throat
Eyes
Respiratory
Cardiovascular
Gastrointestinal
Genitourinary
Endocrine
Productive

[Redacted]

PERMANENT HEALTH SHEET REVIEWED

PHYSICAL EXAM (Check if negative, comment on positives and pertinent negatives)

TEMP = [Redacted]

PULSE = [Redacted]

BP = [Redacted]

- Skin
- Hair/Nails
- Nodes
- Bones/Joints
- Neuromuscular

- Ears
- Nose/Mouth/Throat
- Neck

- Respiratory
- Cardiovascular
- Abdomen
- Genitalia

[Redacted]

[Redacted]

LAB:

[Redacted]

ASSESSMENT

PLAN

[Redacted]

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7/27/92

ST-D-A-P

Patient Information

Date Today

1 Last Nm: [redacted]
2 First Nm: [redacted]
3 Midl Nm: [redacted]
4 Brth Dt: [redacted]
5 Occup : STUDENT
6 Livs w/: [redacted]
7 S S No.: [redacted]

8 -St-No : 4355 PLEASANT
9 City : MPLS
10 State : MN
11 Zip : 55408
12 Phone : [redacted]
13 Ins-Pic: MEDICA
14 Ref Dr:

Doctor : ZATSER
15-Res: Tm: [redacted]
16 Cur Vst: [redacted]
17 Doc : ZATSER
18 Spec: VERB/DIG
19 Prv Vst: 6/1/92
20 Doc : ZATSER
21 Hosp: [redacted]

InAx	1st 10 Meds/Habits	Dosage	Temp Allergies	Problems - last Date
22	SMOKER	loc	12 NONE	41 Liver disease NO
23	^		33	42 Renal Disease NO
24	^		34	43 133 SARDIN
25	^		35	44 2500 2500 2500
26	^		36 Penicillin	45
27	^		37 Alcohol YES	46
28	^		38 Coffee YES	47
29	^		39 Alcohol NO	48 Pna 07/2/92
30	^		40 Diet Pills NO	49 Fla 5/8
31	^		40 Male/F : F	49 Fla 5/8

MMR-6-92

Problem last. contin	Problem last. contin	Problem last. contin	Problem last. contin
32	32	32	32
33	33	33	33
34	34	34	34

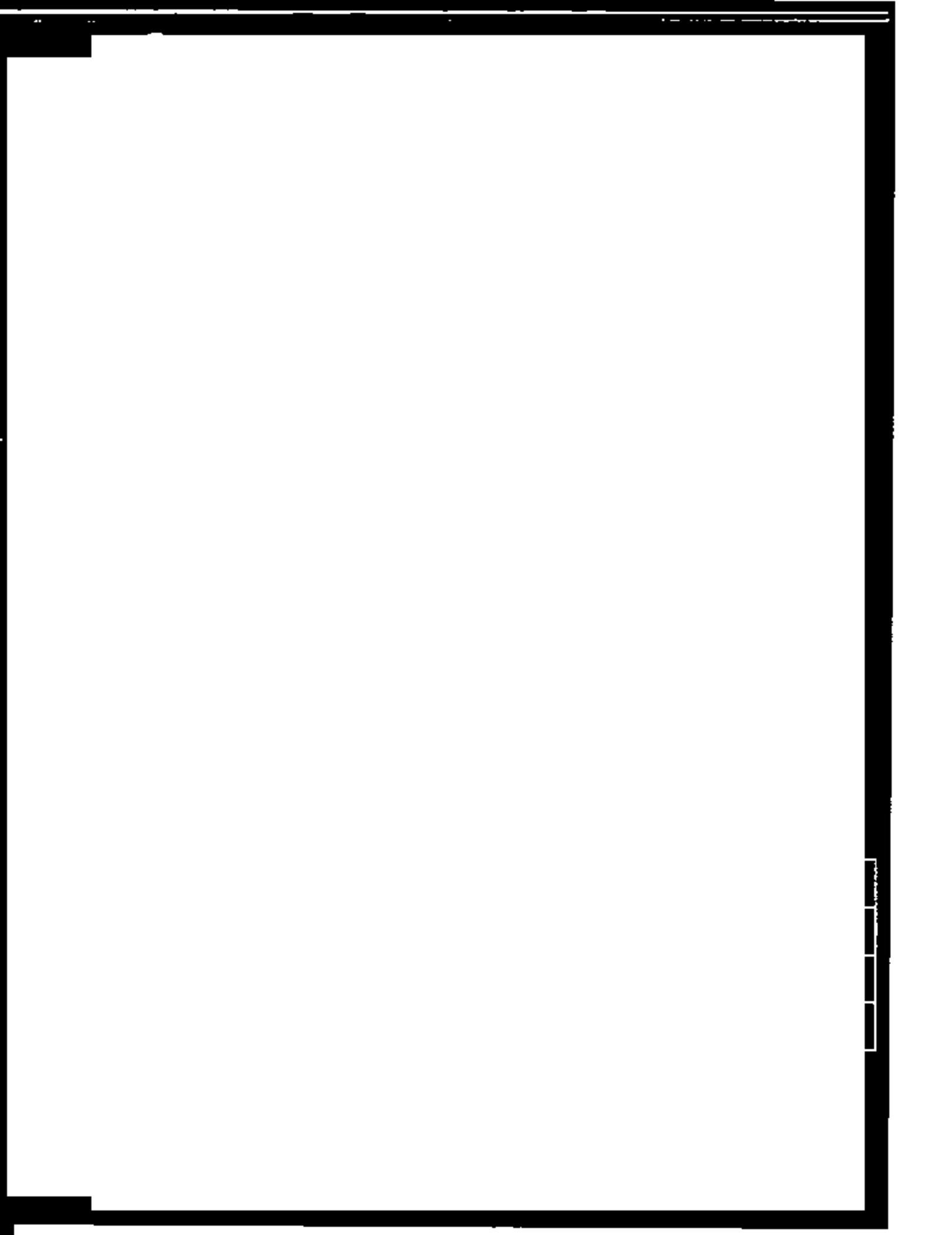
[REDACTED]

- REACTIVE: wt
- General
- Integument
- Nodes
- Bones/Joints
- Neuromuscular
- Head and Neck
- ENT
- Breasts
- Respiratory
- Cardiovascular
- Abdomen
- Genital/Recta

[REDACTED]

ASSESSMENT: [REDACTED]

RD [] DISH. INST: VERBAL [] WRITTEN [] INT [] MD [] R []



[REDACTED]

[REDACTED]

AUTHORIZATION TO RELEASE INFORMATION

I authorize this health care facility to release all medical information, including psychiatric/mental health, chemical dependency and/or AIDS related information to my HMO, insurance company, third party payor, or their designee, as may be necessary for the payment of my bill, determining benefits, or for utilization and quality review purposes for this episode of care.

I further authorize the release of this information to other health care agencies, professionals or persons, who may provide health care services deemed necessary for continuing my medical care.

CONSENT FOR TREATMENT

I authorize the performance of the diagnostic tests, procedures and treatments, and/or the administration of the medications which may be deemed appropriate by the physician, surgeon or other personnel involved in my care. I understand that persons receiving medical training may be involved in my care. I understand that most physicians are not employees or agents of this health care facility, but are independent contractors who have been granted privileges to treat patients in this health care facility. This consent for treatment includes the services which these physicians may perform as well.

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GUARANTEE OF ACCOUNT

I guarantee payment of all charges incurred for treatment and/or confinement of the patient in accordance with the rates and terms of this health care facility.

[REDACTED]

Signature of Patient or Responsible Party

12-6-96
Date

Relationship to Patient

Reason Patient is Unable to Sign

AUTHORIZATION / CONSENT FORM

[REDACTED]

CHART NOTE

[REDACTED]

DOE [REDACTED]

NOVEMBER 15, 1996

I saw [REDACTED] I had seen her in the past in about 1994 on about three occasions. She was involved in an accident on November 6, 1996. She was going down a street. A car without lights came through an intersection which was uncontrolled and hit her on the driver's door and the back. The car spun around. She felt dizzy and light headed. The police took her home and then called an ambulance. She did not report these blocks from the accident. She was told she had a concussion.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

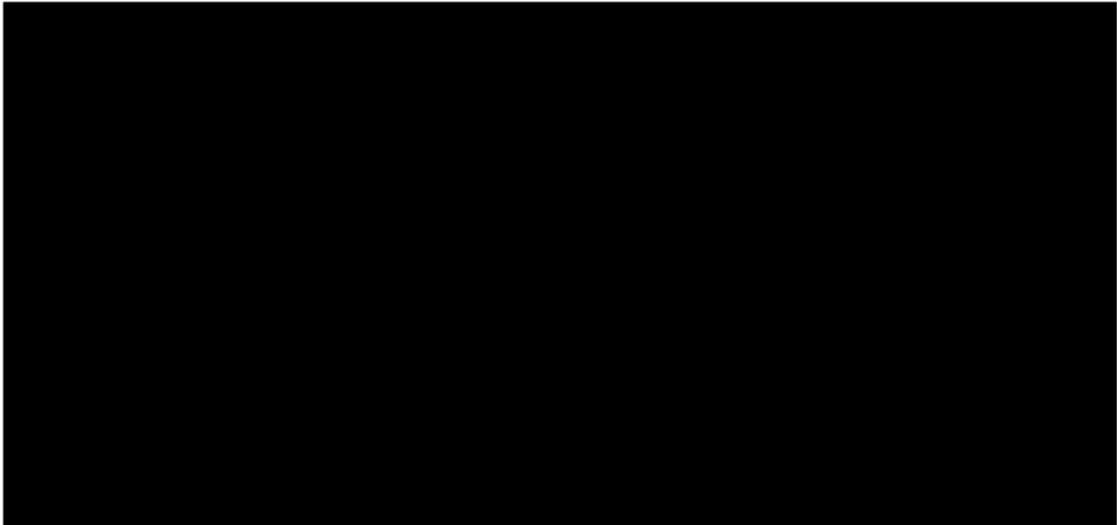


CHART NOTE
PAGE 2
NOVEMBER 15, 1996

RE: 

MENTAL STATUS

The patient is awake, alert, and oriented and has a reasonable fund of information of current events. The patient follows both single and multiple part directions effectively without any evidence of hesitation or confusion. History is related in a coherent, precise fashion.



UPPER EXTREMITIES

RIGHT

LEFT

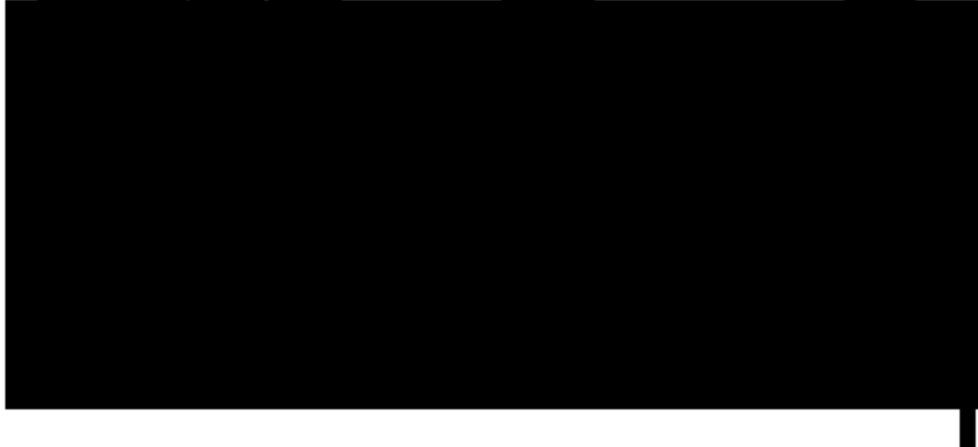
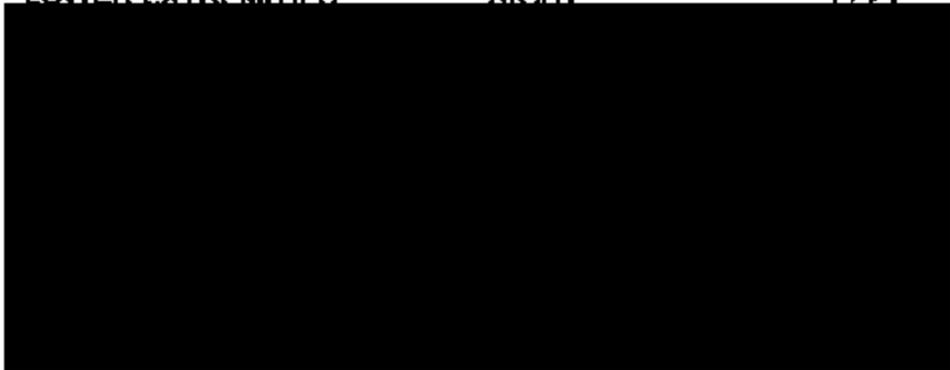




CHART NOTE
PAGE 3
NOVEMBER 15, 1998

RE: 

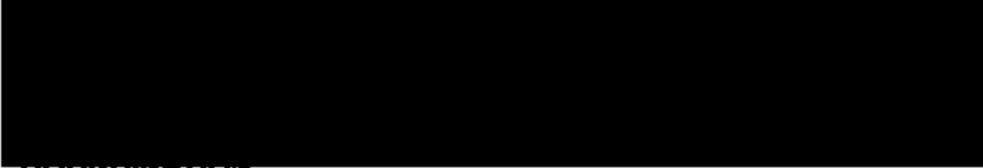
LOWER EXTREMITIES RIGHT LEFT



UPPER EXTREMITIES RIGHT LEFT



LOWER EXTREMITIES RIGHT LEFT



COORDINATION



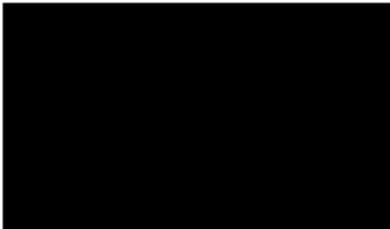


CHART NOTE
PAGE 4
NOVEMBER 15, 1998

RE: 

RANGE OF MOTION



UPPER BODY

TENDERNESS
RIGHT/LEFT

TRIGGER POINTS
RIGHT/LEFT

SPASM
RIGHT/LEFT



LOWER BODY

TENDERNESS
RIGHT/LEFT

TRIGGER POINTS
RIGHT/LEFT

SPASM
RIGHT/LEFT

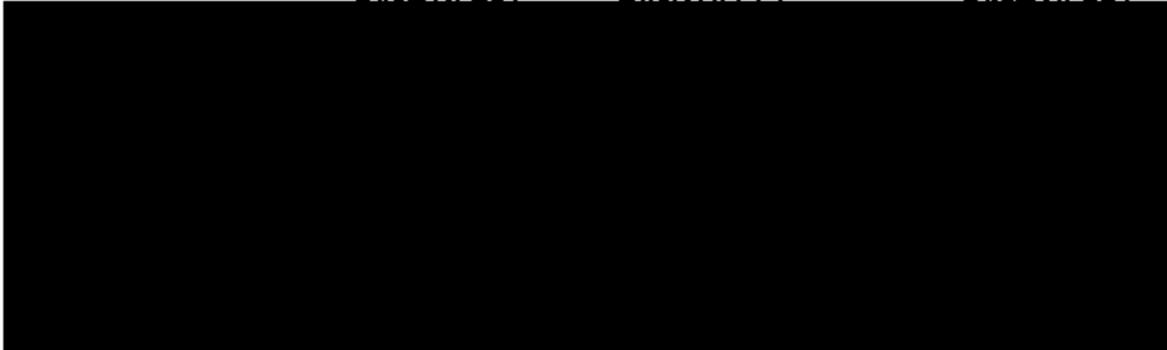


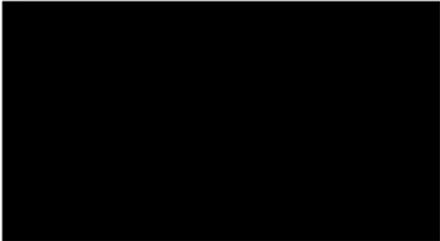


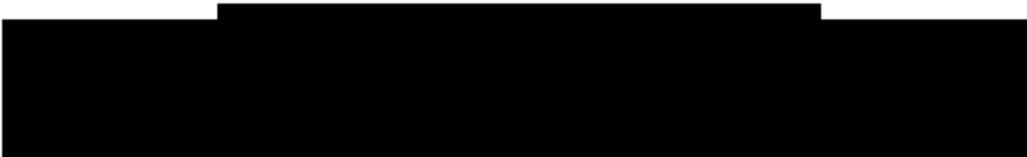
CHART NOTE
PAGE 5
NOVEMBER 15, 1996

RE:



ASSESSMENT:





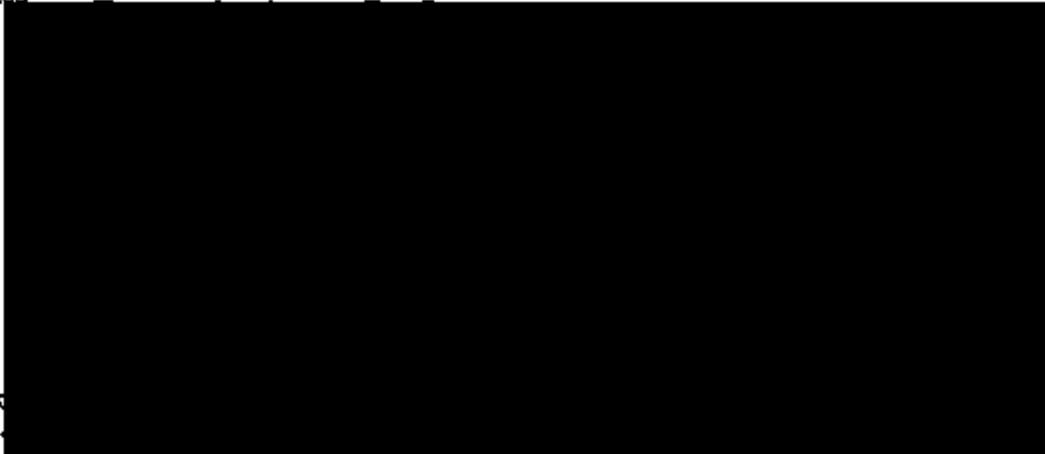
NAME

DATE

11/15/96

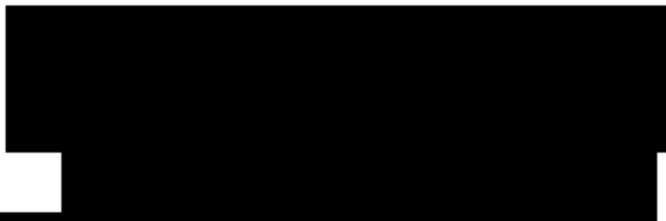
ADDRESS

R



REG. NO.
REFILL

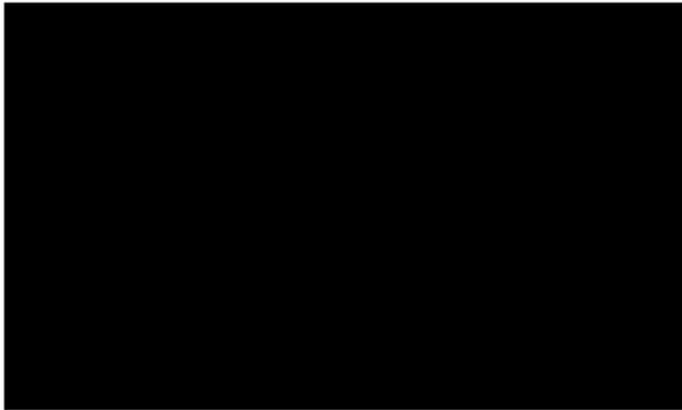
Please Send Progress Notes to Clinic Indicated.



Physiotherapy
863-4446

Patient: _____	FREQUENCY <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x per week DURATION <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 weeks	AREA TO BE TREATED <input type="checkbox"/> Neck & U/back <input type="checkbox"/> Thoracic <input type="checkbox"/> Low back <input type="checkbox"/> U/R L _____ <input type="checkbox"/> L/R L _____
Date: _____		
Diagnosis: _____		
Phone: _____		
Remarks: _____		
Diagnosis: _____		

Evaluation: _____



Modalities:

<input type="checkbox"/> Heat	<input type="checkbox"/> TENS
<input type="checkbox"/> Cold	<input type="checkbox"/> Electrical stimulation
<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Whirlpool
<input type="checkbox"/> Ice Massage	<input type="checkbox"/> Iontophoresis
<input type="checkbox"/> Neuroprobe	

Manual Therapies: Massage

Stabilization

Traction: Pelvic

Cervical

Equipment for Home Use: _____

PCE _____

Work hardening
 _____ x per week for _____ weeks
 Estimated return to work date _____
 Returning to what job _____

Job site assessment

Return to work conditioning program

Goals: Maintain or increase R.O.M. Maintain or increase strength Reduce edema

Relieve pain Relieve muscle spasm Other: _____

Physician's Prior Name: _____

Continuous Previous Treatment: 1 2 3 4 weeks

Frequency: 1x 2x 3x 4x 5x

Physician's Signature _____

Date _____

PATIENT: [REDACTED]
DOB: [REDACTED]
SOC SEC # [REDACTED]
DATE: 11/22/96
PHYSICIAN [REDACTED]

TYPE OF EXAM: [REDACTED]

INDICATION FOR STUDY: [REDACTED]

TECHNIQUE: [REDACTED]

[REDACTED]

FINDINGS: [REDACTED]

[REDACTED]



K

-Continued-

[REDACTED]

[REDACTED]

[REDACTED]

NOVEMBER 22, 1986
PAGE TWO

RE: [REDACTED]
DOB: 08/16/59

IMPRESSION



1. [REDACTED]
2. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

PATIENT: [REDACTED]
DOB: [REDACTED]
SOC SEC #: [REDACTED]
DATE: 11/22/98
PHYSICIAN: [REDACTED]

TYPE OF EXAM: [REDACTED]

INDICATION FOR STUDY: [REDACTED]

TECHNIQUE: [REDACTED]



MINNESOTA
DIAGNOSTIC
CENTER

FINDINGS: Examination at the [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

1. [REDACTED]

K

-Continued-

[REDACTED]

[REDACTED]

CONTINUATION OF MRI REPORT
PAGE TWO
NOVEMBER 22, 1996

RE: [REDACTED]
DOB: 08/16/59

2. [REDACTED]



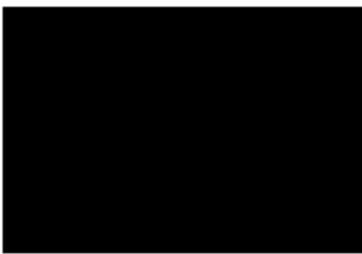


CHART NOTE



DOB:



NOVEMBER 25, 1996

PROBLEMS:

1. Motor vehicle accident - November 5, 1995

- a. [Redacted]
- b. [Redacted]
- c. [Redacted]
- d. [Redacted]

- 2. [Redacted]
- 3. [Redacted]
- 4. [Redacted]

SUBJECTIVE DATA



TREATMENT:



MEDICATIONS:



77

CHART NOTE
NOVEMBER 25, 1996
PAGE 2

RE: [REDACTED]

PAST MEDICAL HISTORY: [REDACTED]

1. [REDACTED]
2. [REDACTED]
3. [REDACTED]

FAMILY HISTORY: [REDACTED]

SOCIAL WORK HISTORY: [REDACTED]

DIAGNOSTIC STUDIES: [REDACTED]

ASSESSMENT: [REDACTED]

1. [REDACTED]
2. [REDACTED]

PLAN:

1. [REDACTED]
2. [REDACTED]
3. [REDACTED]
4. [REDACTED]



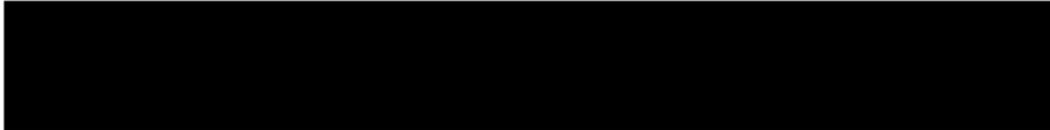
CHART NOTE
NOVEMBER 25, 1996
PAGE 3

RE:

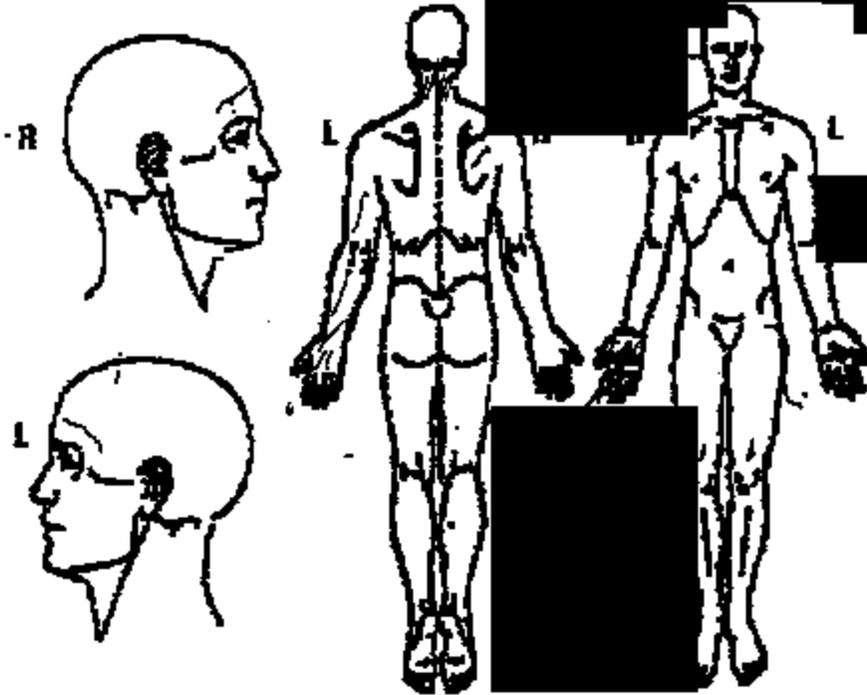


PLAN: (CONTINUED)

5.



SHADE IN AREAS OF DISCOMFORT



PATIENT NAME

11-25-90

DATE

ARE THERE ANY AREAS OF WEAKNESS

ARE THERE ANY AREAS OF NUMBNESS

Since your last visit have your symptoms IMPROVED

NOT CHANGED

OVERALL HEALTH: Have you had any new health problems or injuries since your last visit?

MEDICATIONS: List all medications you currently are taking including those prescribed by others and purchased over the counter:

If you have any **ALLERGIES** please list:

WORK STATUS: Are you currently working?

JOB TITLE:

RESTRICTIONS:

LAST DATE WORKED:

List **FAMILY HEALTH HISTORY** (e.g. blood pressure, heart disease)

What **CONCERNS** do you feel need to be addressed today?

27

CHART NOTE

DOB: [REDACTED]

NOVEMBER 27, 1996

CHIEF COMPLAINT: [REDACTED]

HISTORY: [REDACTED]

EXAMINATION: [REDACTED]

CHART NOTE
NOVEMBER 27, 1996
PAGE 2

RE: [REDACTED]

[REDACTED]

IMPRESSION: [REDACTED]

PLAN: [REDACTED]

[REDACTED]

P/S: [REDACTED]



Name: [Redacted]
Date of Evaluation: December 12, 1996
Referring Physician: [Redacted]
Neuropsychologist: [Redacted]

REASON FOR REFERRAL



SUMMARY



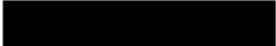
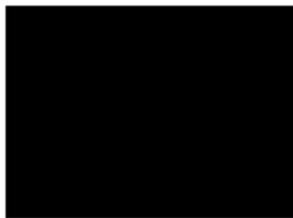


D. [Redacted]

[Redacted]

IMPRESSION

[Redacted]



December 12, 1996

Page 3

RECOMMENDATIONS

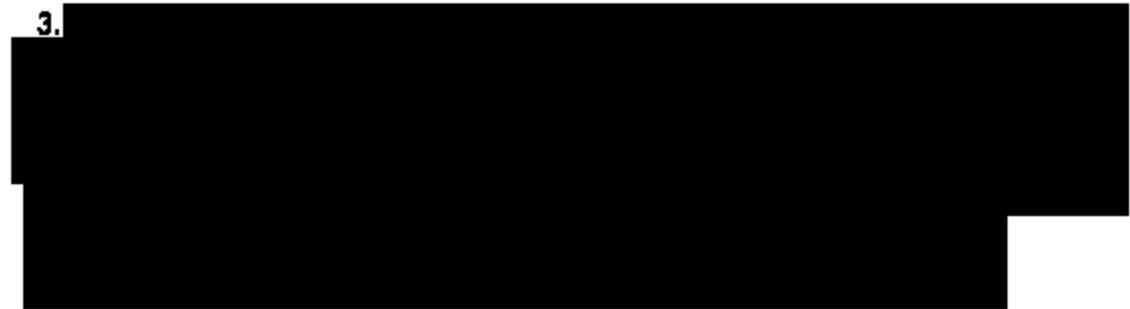
1.



2.



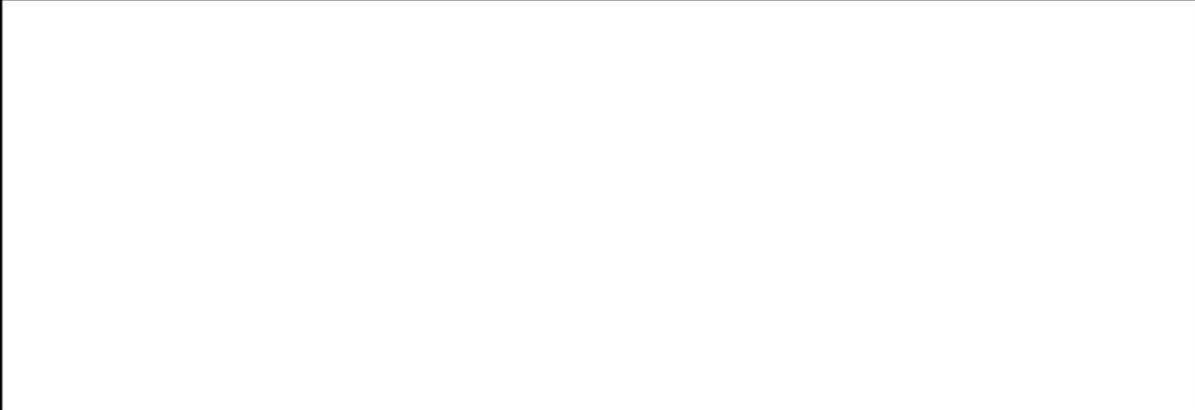
3.





December 12, 1996
Page 4

HISTORY





December 12, 1998

Page 5



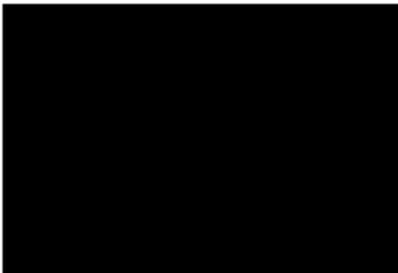
[REDACTED]

December 12, 1996
Page 6

[REDACTED]

BEHAVIORAL OBSERVATIONS

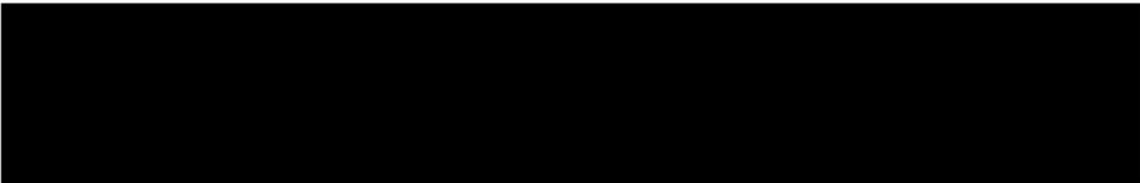
[REDACTED]



December 12, 1996
Page 7

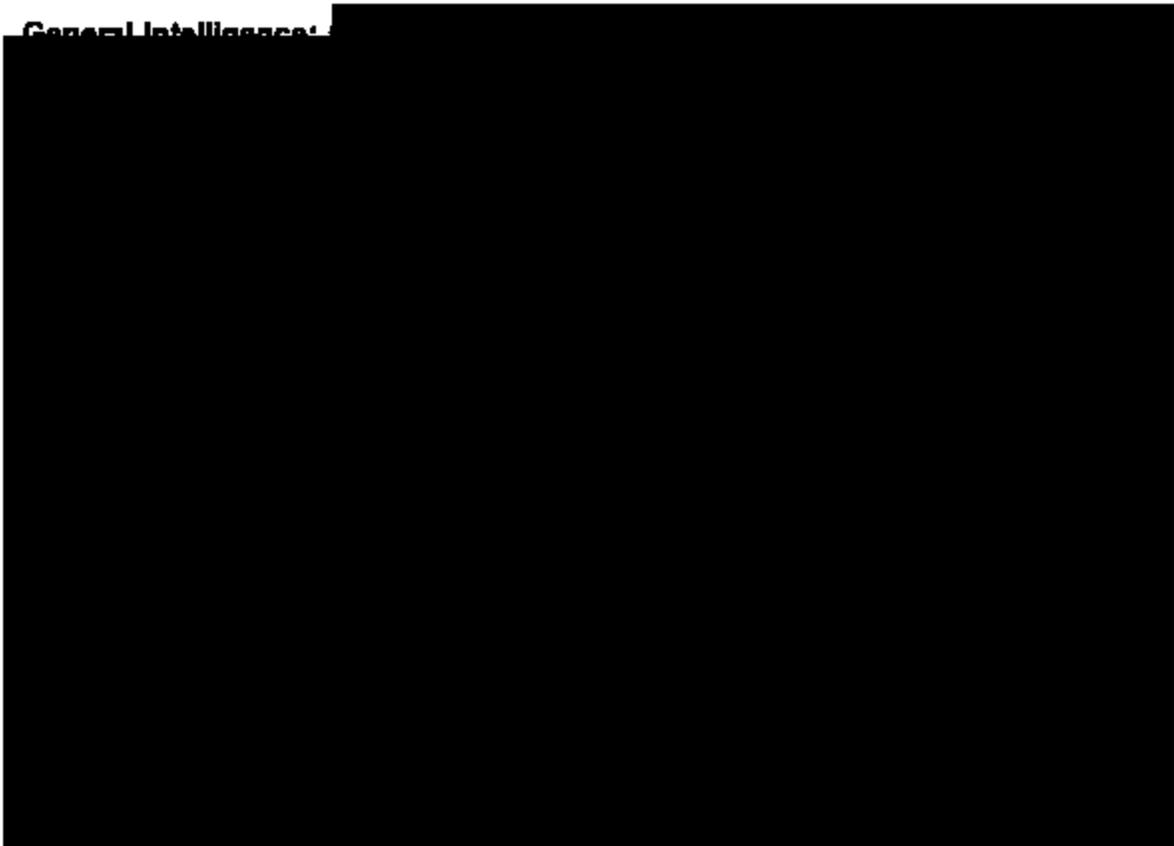


EVALUATION PROCEEDINGS



EVALUATION FINDINGS

General Intelligence:



[Redacted]

97

[Redacted]

December 12, 1996

Page 8

[Redacted]

Language Skills:

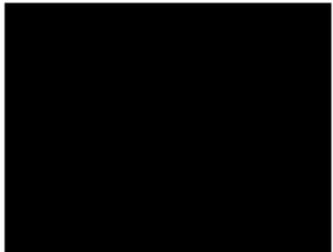
[Redacted]

Attention, Concentration and Mental Tracking:

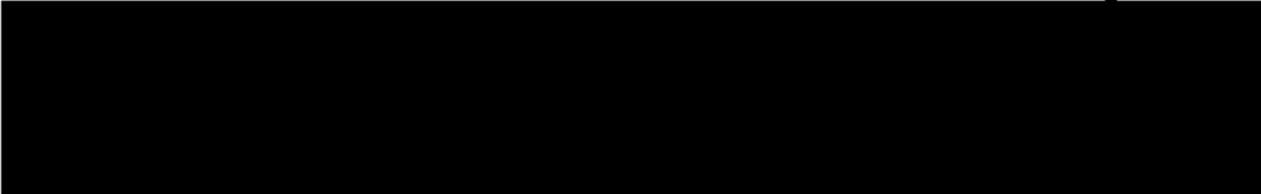
[Redacted]

Learning and Memory:

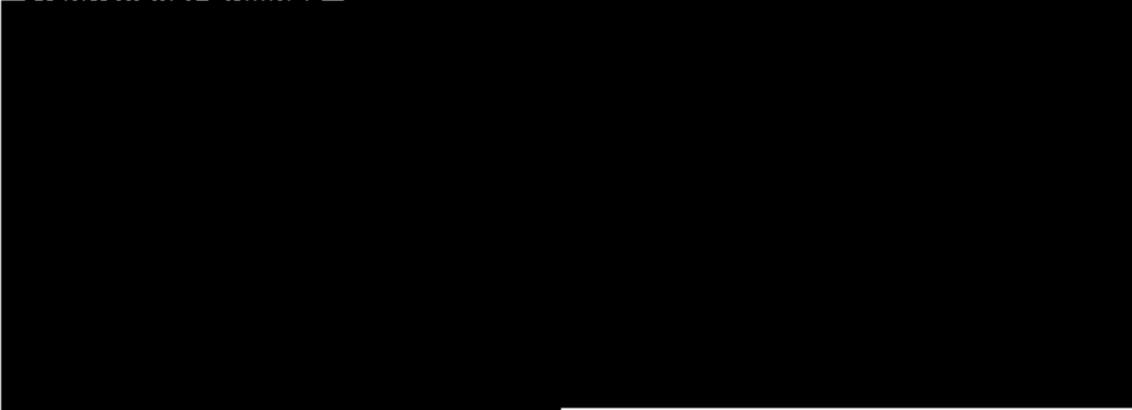
[Redacted]



December 12, 1990
Page 9



Visuospatial Abilities:



Objective Personality Assessment:



[REDACTED]

CHART NOTE

DOE [REDACTED]
JANUARY 9, 1997

PROBLEMS:

- 1.
- 2.
- 3.
- 4.
- 5.

[REDACTED]

SUBJECTIVE

[REDACTED]

OBJECTIVE:

[REDACTED]

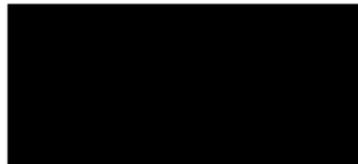
ASSESSMENT:

[REDACTED]

PLAN:

[REDACTED]

101
[REDACTED]



27

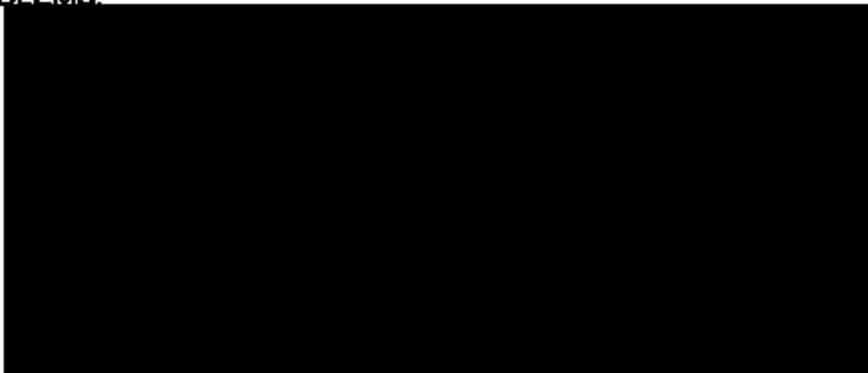
CHART NOTE



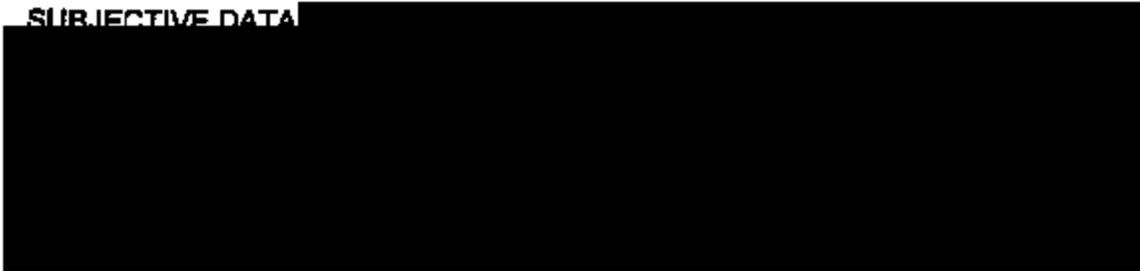
DOB [REDACTED]
JANUARY 13, 1997

PROBLEMS:

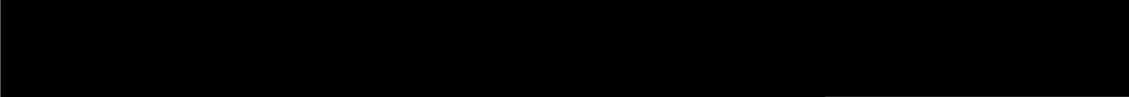
- 1.
- 2.
- 3.
- 4.
- 5.
- 6.



SUBJECTIVE DATA



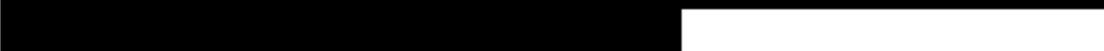
TREATMENT:



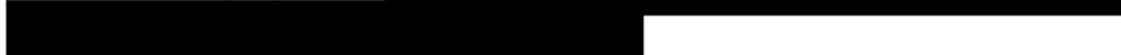
MEDICATIONS:



PAST MEDICAL HISTORY:



SOCIAL/WORK HISTORY:



OBJECTIVE DATA:



[REDACTED]

27

CHART NOTE
Page 2
January 13, 1997

RE: [REDACTED]

[REDACTED]

ASSESSMENT:

[REDACTED]

PLAN:

- 1.
- 2.
- 3.
- 4.
- 5.

[REDACTED]

[REDACTED]

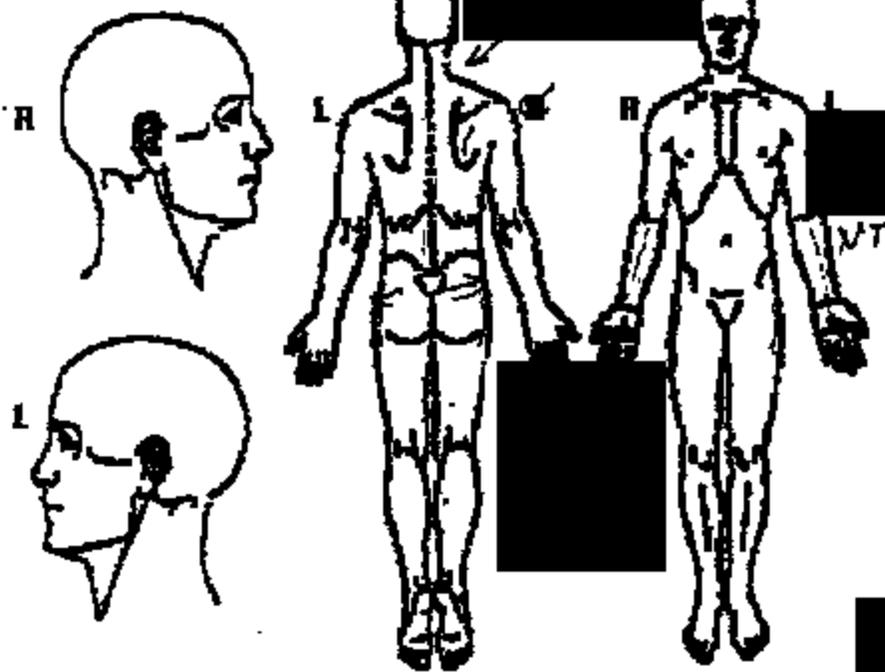
[REDACTED]

SHADE IN AREAS OF DISCOMFORT

[REDACTED]

PATIENT NAME
3-3-97

DATE
[REDACTED]



ARE THERE ANY AREAS OF
[REDACTED]

ARE THERE ANY AREAS OF
NUMBNESS
[REDACTED]

Since your last visit have your symptoms WORSENER NOT CHANGED

What INCREASES or DECREASES your symptoms? [REDACTED]

Have you undergone any TREATMENT or had any TESTS since your last visit?
[REDACTED]

OVERALL HEALTH: Have you had any new health problems or injuries since your last visit?
[REDACTED]

MEDICATIONS: List all medications you currently are taking including those prescribed by others and purchased over the counter. [REDACTED]

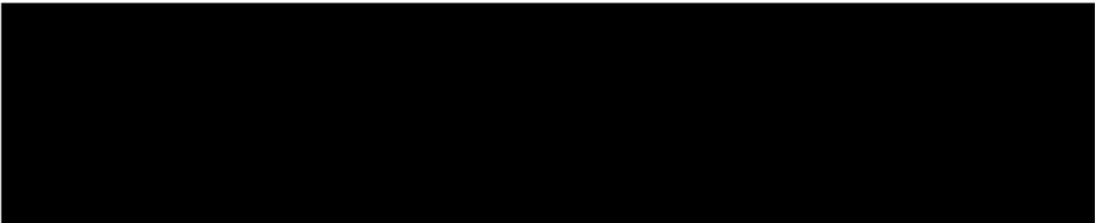
If you have any ALLERGIES please list: [REDACTED]

WORK STATUS: Are you currently working? Yes [REDACTED] TITLE:

RESTRICTIONS: [REDACTED] WORKED:

List FAMILY HEALTH HISTORY. [REDACTED]

What CONCERNS do you feel need to be addressed today?
[REDACTED]



NAME

DATE 3-3-97

ADDRESS

R



REG. NO. _____
REFILL _____ TIMES

NO REFILL _____



M.O.
(OVER)



NAME

DATE 3-21-97

ADDRESS

B



REG. NO.

REFILL TIMES

NO REFILL

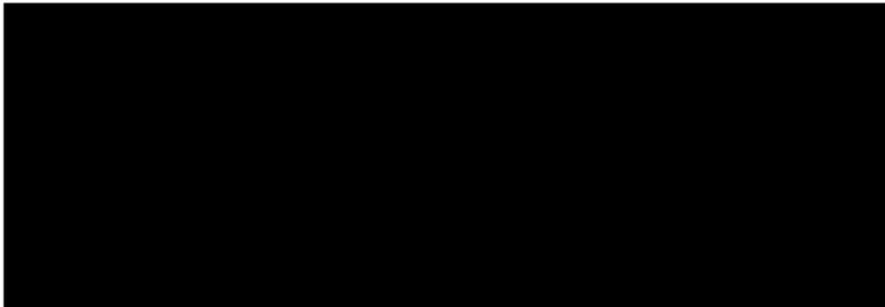




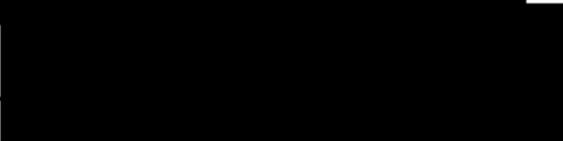
NAME  DATE 5/2/97

ADDRESS _____

R



REG. NO. _____
REFILL _____ TIMES NO REFILL _____



[REDACTED]

CHART NOTE

[REDACTED]

DOB: [REDACTED]

MAY 15, 1997

I saw [REDACTED] today in the office, May 15, 1997. [REDACTED] said she has had her medications changed around. She is now off her [REDACTED]. She is supposed to start [REDACTED]. Her [REDACTED] is supposed to go up to [REDACTED]. She is also taking [REDACTED] at bedtime. She does not do that all the time because sometimes it makes her too sleepy, and she has a child she has to take care of who is [REDACTED]. She has not yet started her [REDACTED] which is going to be an activation exercise type of program for the most part. She is using [REDACTED] now, but does not want to take more [REDACTED]. She said maybe she will use [REDACTED] once in awhile. Her [REDACTED] are down to a level which are about the same as what she had before her last accident, maybe one or two a week, which is not too bad. [REDACTED] She said it is not too bad, but it still surprises her.

[REDACTED]

MENTAL STATUS

[REDACTED]

CRANIAL NERVES

[REDACTED]

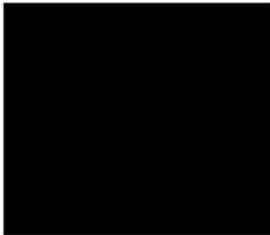


CHART NOTE
PAGE 2
MAY 15, 1987

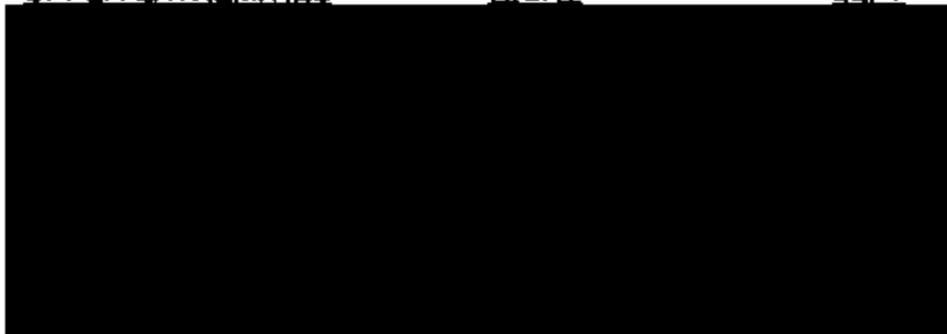
RE 

MOTOR POWER Normal = 5

UPPER EXTREMITIES

RIGHT

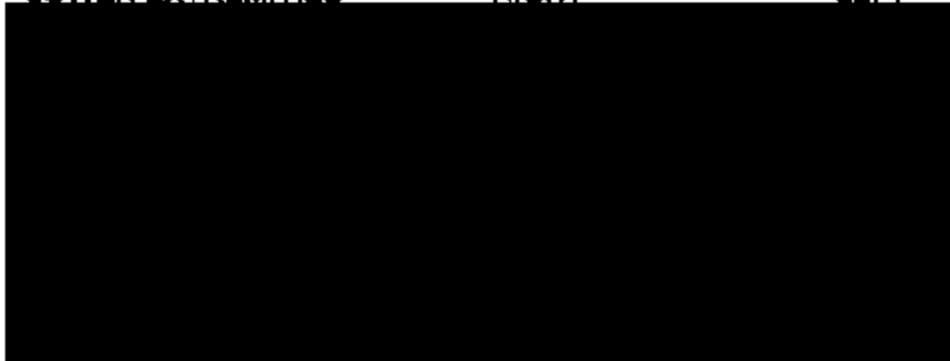
LEFT



LOWER EXTREMITIES

RIGHT

LEFT



REFLEXES Range = 0 to 4

UPPER EXTREMITIES

RIGHT

LEFT





CHART NOTE
PAGE 3
MAY 15, 1997

RE: 

LOWER EXTREMITIES

RIGHT

LEFT



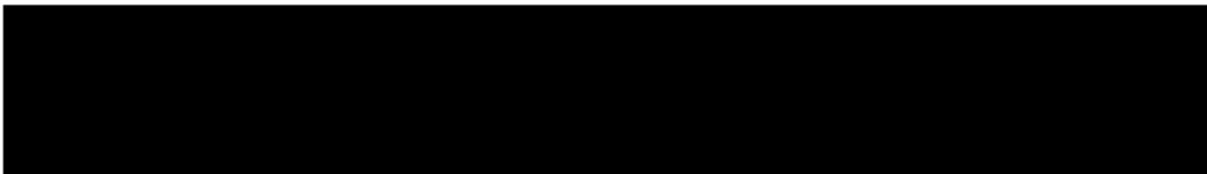
COORDINATION



MUSCLE TONE



GAIT



RANGE OF MOTION

NECK - 

BACK - 



CHART NOTE
PAGE 4
MAY 15, 1997

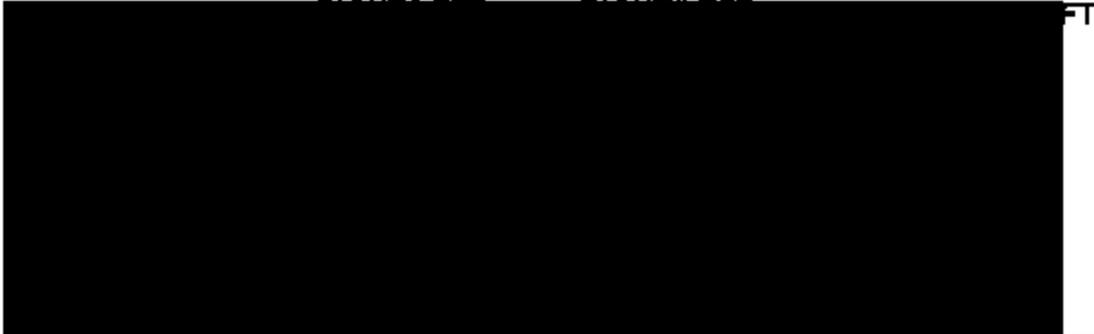
RE: 

PALPATION

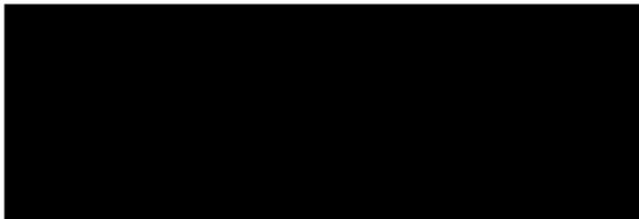
UPPER BODY	TENDERNESS RIGHT/LEFT	TRIGGER POINTS RIGHT/LEFT	SPASM RIGHT/LEFT
------------	--------------------------	------------------------------	---------------------



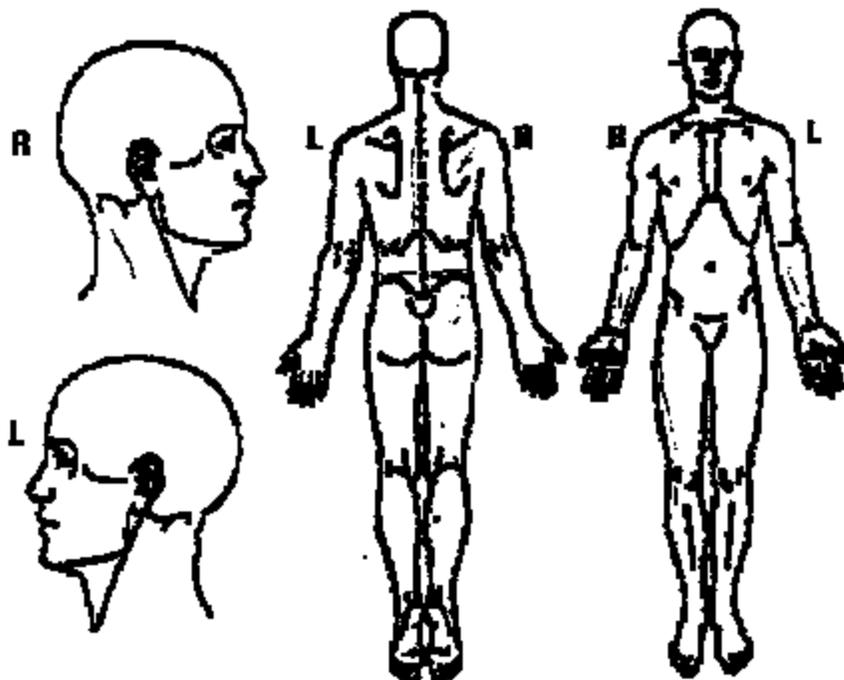
LOWER BODY	TENDERNESS RIGHT/LEFT	TRIGGER POINTS RIGHT/LEFT	SPASM RIGHT/LEFT
------------	--------------------------	------------------------------	---------------------



ASSESSMENT:



SHADE IN AREAS OF DISCOMFORT



[REDACTED]

PATIENT NAME

DATE 5-15-97

ARE THERE ANY AREAS OF WEAKNESS

DESCRIBE:

ARE THERE ANY AREAS OF NUMBNESS

DESCRIBE:

Since your last visit have your symptoms IMPROVED WORSENE

What INCREASES or DECREASES your symptoms?

Have you undergone any TREATMENT or had any TESTS since your last visit?

OVERALL HEALTH: Have you had any new health problems or injuries since your last visit?

MEDICATIONS: List all medications you currently are taking including those prescribed by others and purchased over the counter

If you have any ALLERGIES please list:

WORK STATUS: Are you currently working?

JOB TITLE:

RESTRICTIONS:

LAST DATE WORKED:

List **FAMILY HEALTH HISTORY** (e.g. blood pressure, heart disease)

What **CONCERNS** do you feel need to be addressed today?

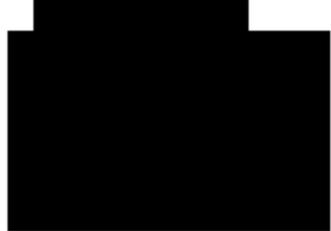


CHART NOTE



DOB: [REDACTED]

JUNE 23, 1997

PROBLEM LIST:

1. [REDACTED]
 - a. [REDACTED]
 - b. [REDACTED]
 - c. [REDACTED]
 - d. [REDACTED]
2. [REDACTED]
3. [REDACTED]
4. [REDACTED]
5. [REDACTED]
6. [REDACTED]

SUBJECTIVE DATA:



TREATMENT:



MEDICATIONS:



PAST MEDICAL HISTORY:



FAMILY HISTORY:



[REDACTED]

CHART NOTE
PAGE 2
JUNE 23, 1987

RE: [REDACTED]

SOCIAL WORK HISTORY: [REDACTED]

OBJECTIVE DATA: [REDACTED]

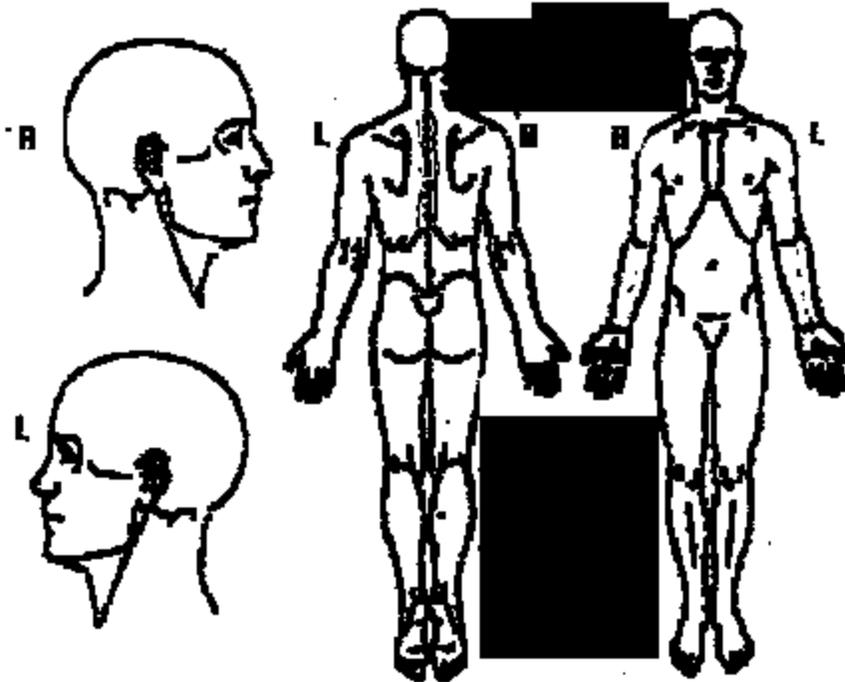
ASSESSMENT: [REDACTED]

PLAN:

1. [REDACTED]
2. [REDACTED]
3. [REDACTED]
4. [REDACTED]

[REDACTED]

SHADE IN AREAS OF DISCOMFORT



[Redacted]

PATIENT NAME

DATE

ARE THERE ANY AREAS OF WEAKNESS

ARE THERE ANY AREAS OF NUMBNESS

TROUBLE

[Redacted]

Since your last visit have you [Redacted]

What INCREASES or DECREASES your symptoms? [Redacted]

Have you undergone any TREATMENT or had any TESTS since your last visit? [Redacted]

OVERALL HEALTH: Have you had any new health problems or injuries since your last visit? [Redacted]

MEDICATIONS: List all medications you currently are taking including those prescribed by others and purchased over the counter: [Redacted]

If you have any ALLERGIES please list: [Redacted]

WORK STATUS: Are you currently working? [Redacted]

JOB TITLE:

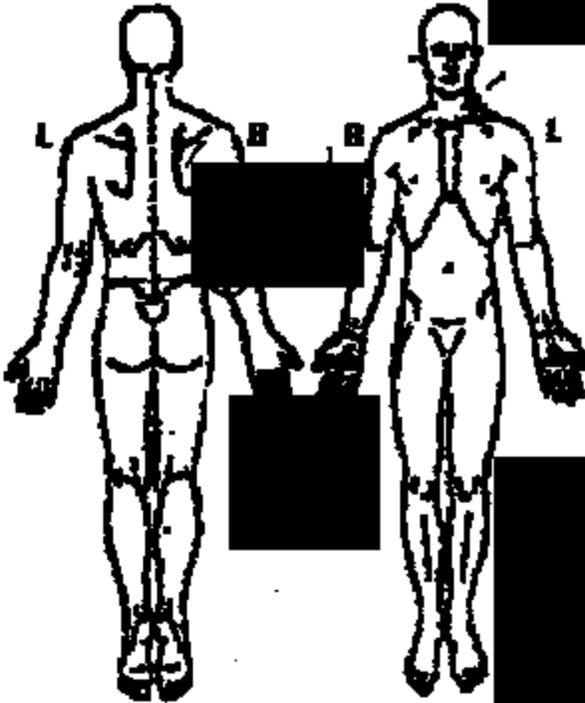
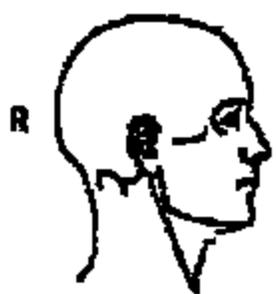
RESTRICTIONS: [Redacted]

LAST DATE WORKED:

List FAMILY HEALTH HISTORY (e.g. blood pressure, heart disease)

What CONCERNS do you feel need to be addressed today? [Redacted]

SHADE IN AREAS OF DISCOMFORT



PATIENT NAME



DATE 1-13-97

ARE THERE ANY AREAS OF WEAKNESS

DESCRIBE:

ARE THERE ANY AREAS OF NUMBNESS

DESCRIBE:

Since your last visit have your symptoms

What INCREASES or DECREASES your symptoms?

Have you undergone any TREATMENT or had any TESTS since your last visit?

OVERALL HEALTH: Have you had any new health problems or injuries since your last visit?

MEDICATIONS: List all medications you currently are taking including those prescribed by others and purchased over the counter:

If you have any ALLERGIES please list:

WORK STATUS: Are you currently working? JOB TITLE:

RESTRICTIONS: LAST DATE WORKED:

List FAMILY HEALTH HISTORY. (e.g. blood pressure, heart disease)

What CONCERNS do you feel need to be addressed today?



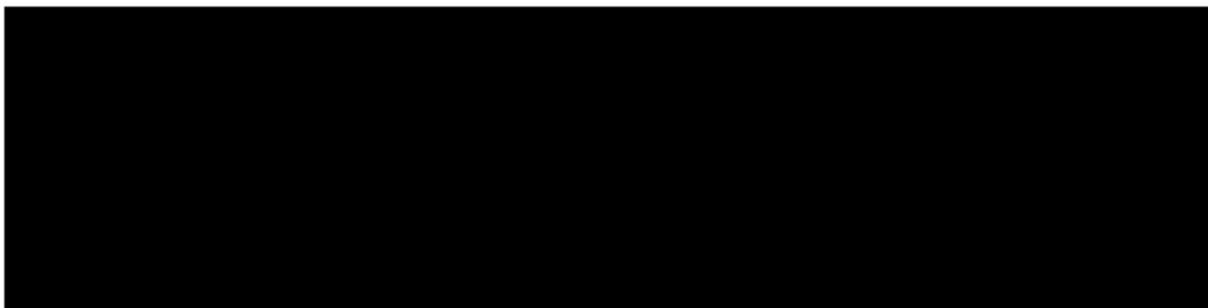
25

CHART NOTE



DOB: [REDACTED]

NOVEMBER 25, 1997



MENTAL STATUS



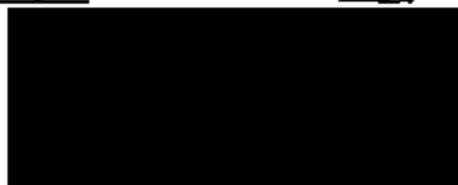
2
3
4
5
6
7
8
9

MOTOR POWER Normal = 5

UPPER EXTREMITIES

RIGHT

LEFT



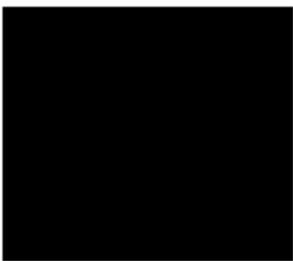
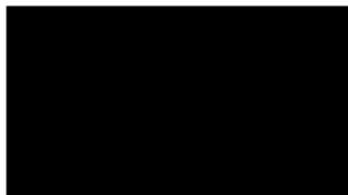


CHART NOTE
PAGE 2
NOVEMBER 25, 1997

RE: 



LOWER EXTREMITIES

RIGHT

LEFT



REFLEXES Range = 0 to 4

UPPER EXTREMITIES

RIGHT

LEFT



LOWER EXTREMITIES

RIGHT

LEFT



COORDINATION



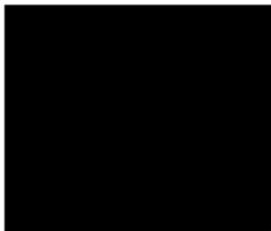


CHART NOTE
PAGE 3
NOVEMBER 25, 1997

RE: [REDACTED]

[REDACTED]

[REDACTED]

SENSORY

[REDACTED]

GAIT

[REDACTED]

RANGE OF MOTION

NECK [REDACTED]

BACK [REDACTED]

PALPATION

UPPER BODY

TENDERNESS
RIGHT/LEFT

TRIGGER POINTS
RIGHT/LEFT

SPASM
RIGHT/LEFT

[REDACTED]

CHART NOTE
PAGE 4
NOVEMBER 25, 1997

RE: [REDACTED]

[REDACTED]

LOWER BODY	TENDERNESS	TRIGGER POINTS	SPASM
	RIGHT/LEFT	RIGHT/LEFT/RIGHT/LEFT	

[REDACTED]

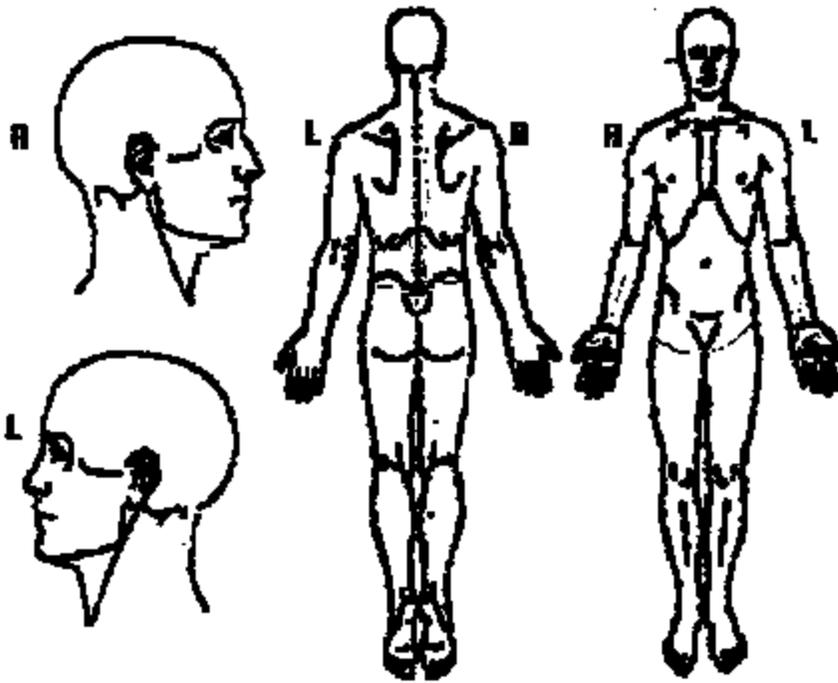
ASSESSMENT

[REDACTED]

[REDACTED]

[REDACTED]

SHADE IN AREAS OF DISCOMFORT



PATIENT NAME
11-25-97

DATE

ARE THERE ANY AREAS OF WEAKNESS

RESISTANCE

ARE THERE ANY AREAS OF NUMBNESS

RESISTANCE

Since your last visit have your symptoms

What INCREASES or DECREASES your symptoms?

Have you undergone any TREATMENT or had any TESTS since your last visit?

OVERALL HEALTH: Have you had any new health problems or injuries since your last visit?

MEDICATIONS: List all medications you currently are taking including those prescribed by others and purchased over the counter.

If you have any ALLERGIES please list:

WORK STATUS: Are you currently working?

JOB TITLE:

RESTRICTIONS:

LAST DATE WORKED:

List FAMILY HEALTH HISTORY (e.g. blood pressure, heart disease)

What CONCERNS do you feel need to be addressed today?

SPECIALIZING IN THE PREVENTION, REHABILITATION, EDUCATION
AND MANAGEMENT OF SPORTS AND ORTHOPEDIC INJURIES

PATIENT INFORMATION

Patient's Name: _____

Diagnosis: _____

Contraindications: _____

Frequency/Duration of Rx: _____

Job: _____

Patient Aware of Diagnosis: _____

EVALUATE AND TREAT

MODALITIES/PROCEDURES REQUESTED BELOW

- | | | |
|---|---|--|
| <input type="checkbox"/> hot pack | <input type="checkbox"/> A.R.O.M. | <input type="checkbox"/> phonophoresis |
| <input type="checkbox"/> cold pack | <input type="checkbox"/> P.R.O.M. | <input type="checkbox"/> home program |
| <input type="checkbox"/> whirlpool | <input type="checkbox"/> work hardening | <input type="checkbox"/> orthotics |
| <input type="checkbox"/> ultrasound | <input type="checkbox"/> interferential current | <input type="checkbox"/> CTL brace |
| <input type="checkbox"/> exercise | <input type="checkbox"/> tens program | <input type="checkbox"/> gait training |
| <input type="checkbox"/> electrical stimulation | <input type="checkbox"/> traction | <input type="checkbox"/> microcurrent |
| <input type="checkbox"/> cybex | <input type="checkbox"/> iontophoresis | |
| <input type="checkbox"/> cybex test | <input type="checkbox"/> massage | |

For All Patients

Physician's Signature

11-25-96

Date

Physical Therapist Signature

12/11/96

Date

PATIENT INFORMATION

Forward 12/11/96

Date: 12-11-96 Date of Inj: 11-6-96

RECEIVED

Name: [Redacted] Date of Birth: [Redacted] Sex: [Redacted]

Address: [Redacted] Street/Box# [Redacted] City: MPLS State: MN Zip: [Redacted]

Home Phone # [Redacted] Work Phone # [Redacted] SS# [Redacted]

Employer (Name & Address): N/A

Referring Physician: [Redacted] Marital Status: [Redacted] M D W

INSURANCE INFORMATION

PRIMARY INSURANCE Group Number

Policy or I.D.# [Redacted] Policy in Name of [Redacted] (if other than self)

Address: [Redacted] Street/Box# [Redacted] City [Redacted] State [Redacted] Zip [Redacted]

Phone # [Redacted] Relationship to Policy Holder [Redacted]

Medicare Number [Redacted] Medicaid Number [Redacted]

SECONDARY INSURANCE Policy or I.D.#

Group Number [Redacted] Relationship to Patient [Redacted]

Address: [Redacted] Street/Box# [Redacted] City [Redacted] State [Redacted] Zip [Redacted]

IF THIS IS A WORKERS' COMPENSATION OR AUTO ACCIDENT CLAIM PLEASE COMPLETE THE FOLLOWING

INSURANCE NAME IDS Property + Casualty Phone#

Address 1400 Lombardi Ave Green Bay WI 54304 Street/Box# City State Zip

CLAIM and/or FILE# [Redacted]

Claim adjuster/rep name [Redacted]

Is this a job related injury? [Redacted] Date of Injury [Redacted]

Is this an auto related injury? [Redacted] Date of Accident 11-6-96

Is an attorney representing you in regard to this injury? If so, name, address & phone number

I, the undersigned, have insurance coverage with [Redacted]

Name of Insurance

and assign directly to S.O.P.T., Inc. all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Name [Redacted] Date 12-11-96

PHYSICAL THERAPY INITIAL EVALUATION

DATE 12/11/96	PATIENT [REDACTED]
REFERRED BY [REDACTED]	PRIMARY MD [REDACTED]
PHYSICAL THERAPIST [Signature]	DIAGNOSIS T/L sprain post traumatic C1/A

General Health
[REDACTED]

Mechanism of Injury
[REDACTED]

Previous Injury
[REDACTED]

General Symptoms
[REDACTED]

Observations
[REDACTED]

Comments
[REDACTED]



SPORTS & ORTHOPEDIC PHYSICAL THERAPY, INC.

"SPECIALIZING IN THE PREVENTION, REHABILITATION, EDUCATION AND SCREENING OF SPORTS AND ORTHOPEDIC INJURIES"



PATIENT INFORMATION

Patient's Name: _____

Diagnosis: _____

Contraindications: *0* _____

Frequency/Duration of Rx: _____

Goals: _____

Patient Aware of Diagnosis: _____

EVALUATE AND TREAT _____

MODALITIES/PROCEDURES REQUESTED BELOW

- ___ hot pack
- ___ cold pack
- ___ whirlpool
- ___ ultrasound
- ___ exercise
- ___ electrical stimulation
- ___ cybex
- ___ cybex test

- ___ A.R.O.M.
- ___ P.R.O.M.
- ___ work hardening
- ___ interferential current
- ___ tens program
- ___ traction
- ___ iontophoresis
- ___ massage

- ___ phonophoresis
- ___ home program
- ___ orthotics
- ___ CTI brace
- ___ gait training
- ___ microcurrent

For All Patients: _____

Physician's Signature

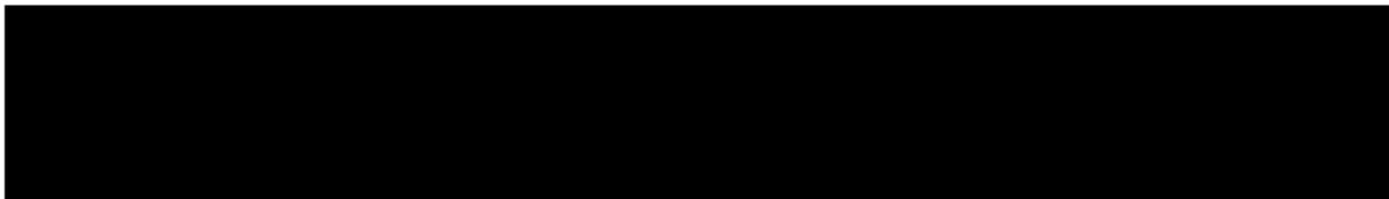
11-25-96

Date

Physical Therapist Signature

12/11/96

Date



DATE: December 11, 1996

REFERRING PHYSICIAN: [REDACTED]

PATIENT: [REDACTED]

DOB: [REDACTED]

DIAGNOSIS: [REDACTED]

PROGRESS NOTE

SUBJECTIVE:

Patient reports being in a motor vehicle accident on 11-06-96. Patient reported she was driving and she was hit on the left side at the rear half of her car and spun around. Patient reports obtaining a concussion from this accident.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

OBJECTIVE:

Active cervical motion has full motion, however has complaint of pulling at the end range of side bending and pinching at full extension. Active trunk range of motion: Flexion 80 percent, extension 75 percent, bilateral rotation full, bilateral side bending 80 percent.

A decrease in flexibility is noted for cervical and lumbar paraspinals, along with scalenes and pectoralis muscles.

Manual muscle testing for bilateral lower extremity 5/5, bilateral upper extremity 5/5, cervical muscles 5/5. Upper back musculature: Rhomboids bilaterally 5/5, lower traps bilaterally 4+/5, middle traps bilaterally 4+/5, and laterals bilaterally 4/5.

Continued...

DATE: December 11, 1996

REFERRING PHYSICIAN: [REDACTED]

PATIENT: [REDACTED]

DOB: [REDACTED]

DIAGNOSIS: [REDACTED]

Continued...

[REDACTED]

ASSESSMENT: [REDACTED]

PLAN: [REDACTED]

GOALS:

Short-term goals:

1. [REDACTED]
2. [REDACTED]

Long-term goals:

1. [REDACTED]
2. [REDACTED]
3. [REDACTED]

Thank you, [REDACTED], for your referral of this patient.

[REDACTED]

PHYSICAL THERAPY OBJECTIVE EVALUATION

DATE

12/11/96

PATIENT

006

ROM

Flexibility

Strength

NTIC

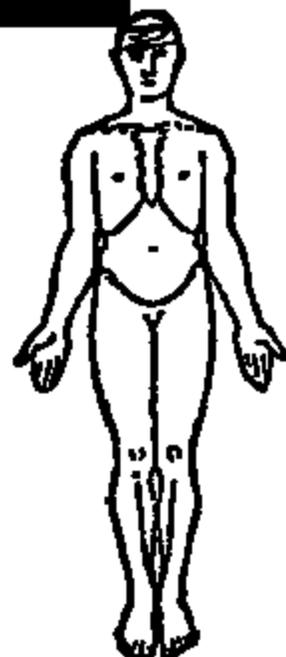
Palcation

Special Tests

Objective Goals

Functional Goals

Psychological / vocational intervention candidate
Patient understands diagnosis / prognosis
Vulnerable adult



PHYSICAL THERAPY INITIAL EVALUATION

DATE 12/11/96

PATIENT [REDACTED] DOB: [REDACTED]

REFERRED BY [REDACTED]

PRIMARY MD [REDACTED]

PHYS [REDACTED]

General Health

Mechanism of Injury

Previous Injury

Present Symptoms

Present Medications

Observations

Comments



**SPORTS & ORTHOPEDIC
PHYSICAL THERAPY, INC.**



PATIENT UPDATE REPORT

Patient Name:



Physician:



Date:

1/10/97

DOB:

8/16/57

Involved Joint:



Seen 3 times in P.T.

SUBJECTIVE:



OBJECTIVES:



PLAN:



Therapist:





**SPORTS & ORTHOPEDIC
PHYSICAL THERAPY, INC.**



PATIENT UPDATE REPORT

Patient Name: [REDACTED] Physician: [REDACTED]
Date: 2/19/97 DOB: 8/16/59 Involved Joint: C7/T2 Strain / Sprain



SUBJECT:



OBJECTIVE:



ASSESSMENT:



PLAN:



Therapy:





SPORTS & ORTHOPEDIC PHYSICAL THERAPY, INC.

*"SPECIALIZING IN THE PREVENTION, REHABILITATION, EDUCATION
AND SCREENING OF SPORTS AND ORTHOPEDIC INJURIES"*



PATIENT INFORMATION

Patient's Name: 

Diagnosis: 

Contraindications: _____

Frequency/Duration of Rx: _____

- Goals: Increase Strength Decrease Pain
 Increase R.O.M. Reduce Muscle Spasm
 Reduce Edema Other _____

Patient Aware of Diagnosis: Yes No

EVALUATE AND TREAT

MODALITIES/PROCEDURES REQUESTED BELOW

- | | | |
|---|--|--|
| <input type="checkbox"/> hot pack | <input type="checkbox"/> A.R.O.M. | <input type="checkbox"/> phonophoresis |
| <input type="checkbox"/> cold pack | <input type="checkbox"/> P.R.O.M. | <input type="checkbox"/> home program |
| <input type="checkbox"/> whirlpool | <input type="checkbox"/> work hardening | <input type="checkbox"/> orthotics |
| <input type="checkbox"/> ultrasound | <input type="checkbox"/> interferential current | <input type="checkbox"/> CTI brace |
| <input type="checkbox"/> exercise | <input type="checkbox"/> tens program | <input type="checkbox"/> gait training |
| <input type="checkbox"/> electrical stimulation | <input type="checkbox"/> traction | <input type="checkbox"/> re-education |
| <input type="checkbox"/> cybex |  | |
| <input type="checkbox"/> cybex test | | |

• For All Patients

• Locker rooms and showers available

• Accessible through skyway system

Physician's Signature

3-3-97

Date

Physical Therapist Signature

Date

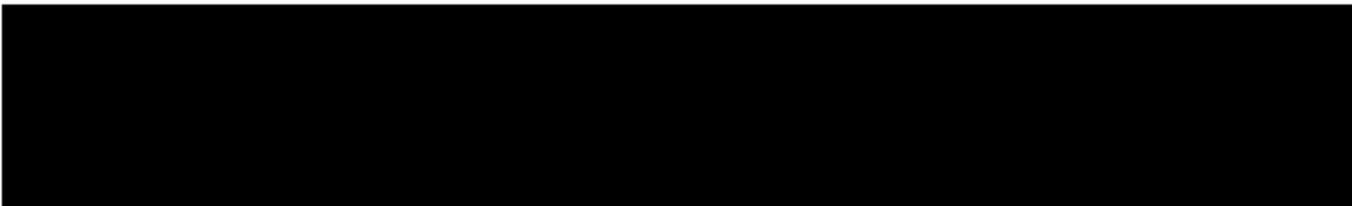


CHART NOTE
PAGE 2
SEPTEMBER 8, 1994

RE: [REDACTED]

Normal = [REDACTED]

RIGHT

LEFT

LOWER EXTREMITIES

RIGHT

LEFT

Range [REDACTED]

RIGHT

LEFT

RIGHT

LEFT

[REDACTED] [REDACTED]

CHART NOTE
PAGE 3
SEPTEMBER 8, 1994

RE: [REDACTED]

[REDACTED]
[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

DICTATED NOT READ

[REDACTED]

D: 9-08-94
T: 8-12-94

CHART NOTE

DOB: [REDACTED]

OCTOBER 7, 1994

[REDACTED]

Dictated Not Read

[REDACTED]

MDB:sv

D: 10-07-94

T: 10-11-94

[REDACTED]

CHART NOTE

[REDACTED]

DOB: [REDACTED]

NOVEMBER 22, 1994

I saw [REDACTED]

[REDACTED]

[REDACTED]

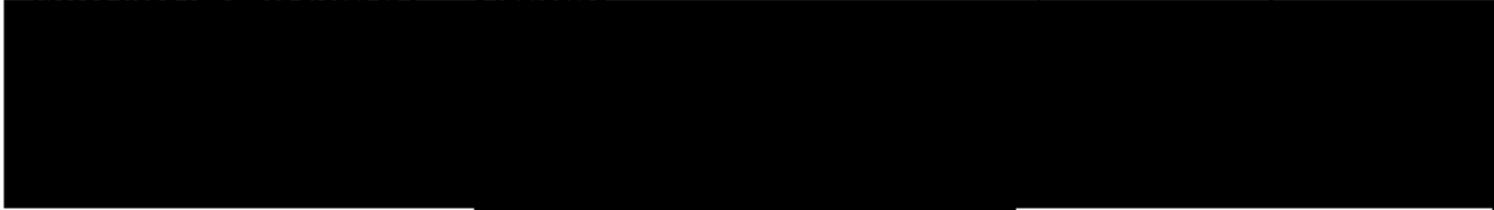
[REDACTED]

DICTATED NOT READ

[REDACTED]

D: [REDACTED]
T: 11/28/94

Handwritten notes



Patient: _____
 Date: _____
 Diagnosis: _____
 Phone: Work: _____ Home: _____
 Remarks: _____
 Diagnostic tests: _____

FREQUENCY
 1x 2x 3x 4x 5x per week

DURATION
 1 2 3 4 weeks

AREA TO BE TREATED

Neck & U/back
 Thoracic
 Low back
 L/E R/L _____

Evaluation:

_____ and proceed with Rx
 Treat specifically as ordered
 Home program only

Modalities:

Heat TENS
 Cold Electrical stimulation
 Ultrasound Whirlpool
 Ice Massage Iontophoresis
 Neuroprobe

Manual Therapy:

Massage
 Mobilization

Traction:

Pelvic
 Cervical

Equipment for Home Use: _____

Low back exercise _____ Program
 Back education Nautilus
 Conditioning Swim Program
 Gait training Combined Nautilus-Swim
 Upper extremity exercise Orthotics
 Lower extremity exercise Other _____
 ACE _____
 Work hardening
 _____ x per week for _____ weeks
 Estimated return to work date _____
 Returning to what job _____
 Job site assessment
 Return to work conditioning program

Goals: Maintain or increase R.O.M. Maintain or increase strength Reduce edema
 Relieve pain Relieve muscle spasm Other: _____

Physician's Signature _____
 Print Name _____

Continuous Previous Treatment: 1 2 3 4 weeks
 Frequency: 1x 2x 3x 4x 5x
 Physician's Signature _____
 Date _____

MINNEAPOLIS MN
PHONE

PATIENT:
DOE
SOC SEC #:
DATE:
REFERRING:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]	DISTANCE	LATENCY	AMPLITUDE		COND. VEL.
			PROXIMAL	DISTAL	
[REDACTED]					
[REDACTED]					

[REDACTED]

[REDACTED]	FIBS	FASC	MOTOR UNIT ACTION POTENTIALS	
	[REDACTED]			
[REDACTED]				

EMG

October 07, 1994

Page 2

RE: [REDACTED]

IMPRESSION: [REDACTED]

DICTATED NOT READ

Michael D. Bromer, M.D.
Board Certified Electromyographer
MDB:sv

DOB: [REDACTED]

September 19, 1996

INITIAL OFFICE VISIT:

[REDACTED] is a [REDACTED] year old

PAST MEDICAL HISTORY: [REDACTED]

MEDICATIONS:

None.

ALLERGIES:

None.

HABITS:

REVIEW OF SYSTEMS:

FAMILY HISTORY:

PAIN DIAGRAM:

SOCIAL HISTORY:

PHYSICAL EXAM:

DOB: [REDACTED]

September 19, 1996 continued . . .

[REDACTED]

X-RAYS:

[REDACTED]

RECOMMENDATIONS:

The following recommendations are based on further discussion with [REDACTED]

[REDACTED] It is difficult to determine exactly where [REDACTED] symptoms are arising. We have indicated to her that her symptoms are not amenable to surgical treatment. We have recommended that she see [REDACTED] to be evaluated for possible [REDACTED]. Should she have further questions or concerns she may contact our office at any time.

JES/SDB:TT/mz

[REDACTED]

SOUTHDALE
October 31, 1996
OFFICE CALL:

[REDACTED] was seen by [REDACTED] was

normal.

[REDACTED]

EXAMINATION:

[REDACTED]

[REDACTED]

[REDACTED]

JES:TT/sr

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

PHYSICAL THERAPY OUTPATIENT PROGRESS NOTE:

Referring Diagnosis: [REDACTED]

SUBJECTIVE: [REDACTED]

ASSESSMENT: [REDACTED]

PLAN: The patient will see [REDACTED] today, and we will await further orders regarding further treatment for this patient.

GOALS: At this time, the goals which were set at the initial evaluation of allowing the patient to stand for 1 hour without pain, sit for 1 hour without pain, and become independent in the management and prevention of further back and right hip pain are close to being met, but have not been met at this time.

[REDACTED]

[REDACTED]

[REDACTED]

INITIAL PHYSICAL THERAPY OUTPATIENT EVALUATION:

Referring Diagnosis: [REDACTED]

SUBJECTIVE:

Chief Complaint: [REDACTED]

Age/Sex/Occupation: [REDACTED]

Onset: The patient reports that she has had increased pain since she was involved in a motor vehicle accident in November of 1996 when she was hit from the side.

Current History: The patient noticed pain right away after the accident.

[REDACTED] This gave her good temporary relief, but did not cause any prolonged change.

Past History: [REDACTED]

REVIEW OF SYSTEMS:

Pain Survey: [REDACTED]

Pain Scale: 8 on a scale of 0-10

Aggravating Factors: [REDACTED]

Easing Factors: [REDACTED]

[REDACTED] in the groin area.

OBJECTIVE:

Handedness: [REDACTED]

Body type: [REDACTED]

Posture: [REDACTED]

left. The [REDACTED]

[REDACTED]

Palpation:

TREATMENT PLAN/FUNCTIONAL GOALS:

DWD/lmr/7623#4

[REDACTED]

NAME

DATE

6/23/97

ADDRESS

R

[REDACTED]

REG. NO.

REFILL _____ TIMES

NO REFILL _____

[REDACTED]

NAME: _____

SS #: _____

DATE

--	--

NAME: _____

SS #: _____

DATE _____

[REDACTED]

25

December 3, 1997

Veronica Casey
Veronica Casey Law Offices, Ltd.
701 Fourth Avenue S. Suite 500
Minneapolis, MN 55415

Re: [REDACTED]
DOB: [REDACTED]

Dear Ms. Casey:

I have seen [REDACTED] on a number of occasions regarding a car accident on November 6, 1996. I actually saw her about 10 days after her accident. She has been seen in my office a number of times since then, the last being on November 25, 1997. She described the accident which occurred on November 6, 1996. A car without lights came through an intersection and hit her vehicle on the driver's door. Her car spun.

[REDACTED]

[REDACTED]

[REDACTED]

92

Veronica Casey
December 3, 1997
Page 2

Re: [REDACTED]

[REDACTED] I base this

[REDACTED]
come and go. She did not have that prior to her accident.

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

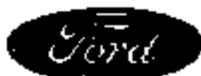
I hope this information is helpful to you. If you have any further questions, please don't hesitate to contact me.

Sincerely,

[REDACTED]
[REDACTED]
[REDACTED]

mdb/pts/sw

D: 12-03-97
R: 12-03-97
T: 12-05-97



Office of the General Counsel

Ford Motor Company
Parklane Towers West
Suite 400
Three Parklane Boulevard
Dearborn, Michigan 48126-2500

February 4, 1997

[REDACTED]
Minneapolis, MN [REDACTED]

Dear [REDACTED]

We acknowledge your recent contact to Ford Motor Company. Your complaint has been directed to this office for further handling. In order to assist us in evaluating your claim, we request that you provide us with the following information:

1. The date of incident and the city and state in which it occurred.
2. A complete description of the incident, including events which occurred prior to and subsequent to the loss.
3. A copy of the police and/or fire report.
4. For each person alleged injured: full name, date of birth, home address, marital status and name of spouse, social security number, occupation, a complete description of the injuries, the names and addresses of all treating physicians, and copies of all medical bills and reports.
5. The vehicle year, model, and serial number.
6. The mileage on the vehicle at the time of the incident.
7. Original photographs of the vehicle's collision/fire damage, *from several different angles*, or color laser copies.
8. Original photographs of the inside of the vehicle showing the steering wheel, dash and roof areas.
9. Original photographs of the accident scene showing the grade of the road.
10. What is the alleged defect?
11. Documentation to substantiate your defect allegation, including a copy of your expert's report and the expert's original photographs.
12. Has the alleged defective part been repaired or replaced?
13. The present location of the alleged defective part and the vehicle.
14. The repair estimate, repair order, or your total loss worksheet for the vehicle's damage, and copies of draft payments.
15. A complete service history for the subject vehicle, including any tune-ups or oil changes.

01/22/97 MASTER OWNER RELATIONS SYSTEM 11 03.46.22
=====

TEAM: LP 17290H	INQUIRY CONTACT	VEN TYPE: CAR
TWIN CITIES 58 ZN/TR: 01	CONTACT NBR: 107996748	OPENED: 01/21/1997
VIN: 1ZVPT20C3R5		CLOSED: 01/21/1997

=====

LAST NAME: [REDACTED]	FIRST NAME: [REDACTED]	STATUS: CLOSED
TITLE: [REDACTED]	MI: [REDACTED]	
ADDRESS: [REDACTED]		
CITY: MINNEAPOLIS	STATE: MN	ZIP: [REDACTED]
HOME PHONE: [REDACTED]	BUS. PHONE: [REDACTED]	
MODEL YEAR: 91	MODEL: PROBE	
MILEAGE: 100000	MSD: [REDACTED]	

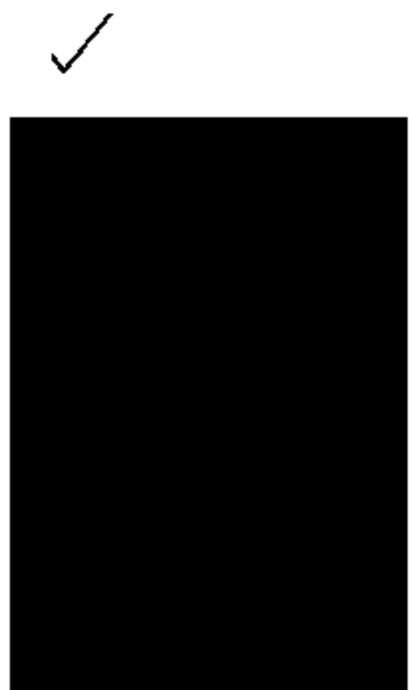
DEALER NAME: FREEWAY FORD INC SALES CODE: 150005 PA CODE: 09420
CAURAL CODE: SYMPTONS:
INQUIRY CODE: 1420 ALLEGED PERSONAL INJURY - INQUIRY



FOLLOW UP: M COMM TYPE: MICRO NBR: LETTER CODE:

COMMENTS:
1997/01/21

NAVIS-SUBSEQUENT**PREVIOUS CONCERN 106274380ALLEGED INJURY****
ATTORNEY LETTER DATED 12/2/96; RECEIVED BY LEGAL ON 1/13/97
ATTORNEY WRITES:
-CLIENT WAS INJURED WHEN SEAT BELT SHE WAS WEARING BROKE IN HALF.
-DEMANDS THAT FORD FURNISH ATTORNEY WITH THE NAMES AND ADDRESS OF ALL PERSON OR COMPANIES KNOWN TO BE IN THE CHAIN OF MANUFACTURE AND DISTRIBUTION OF THE DESCRIBED DEFECTIVE PRODUCT.
*
LPA MADE OBC TO ATTORNEY OFFICE AND SPOKE WITH SEC ON 1/14/97, 1/16/97 AND AGAIN ON 1/17/97, FINALLY GETTING VIN IN ORDER TO DOCUMENT LETTER
-ADVISED SECRETARY/ANNE THAT THE ATTORNEY'S LETTER WOULD BE FORWARDED TO THE APPROPRIATE OFFICE AND THE ATTORNEY WOULD BE RECONTACTED
-NO TIME FRAME.



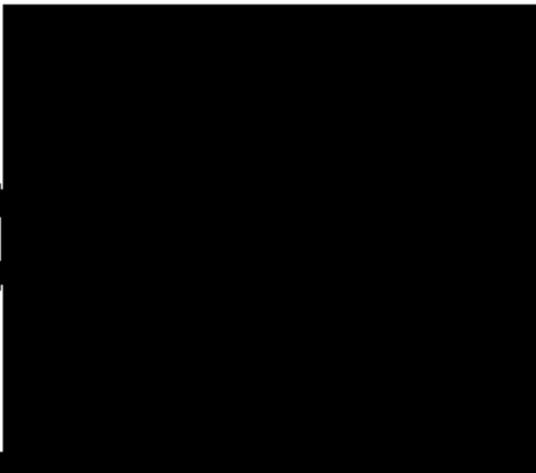
0R0062

MORS II Inquiry Contact

01/21/1997 09:27:34

VIN CITIES 58 Zn/Tr: B1 M/A: CONTACT NBR: 107996748 Opened: 01/21/1997
 N: 1ZVPT20C3M5 Analyst: 1729DH Closed: 01/21/1997
 Last Name: [REDACTED] First Name: [REDACTED] Status: CLOSED
 Title: [REDACTED] MI:
 Address: [REDACTED]
 City: MINNEAPOLIS ST/PV: MN Zip/PC [REDACTED] CC: USA
 Home Phone: [REDACTED] Business Phone: [REDACTED] Ext:
 Fax: 91 Model: PROBE
 Mileage/Km: 100000 WSD: 05/31/1991
 Dealer Name: FREEWAY FORD INC SALES CODE: 158005 P&A: 09420
 Fiscal Code: Symptoms:
 Inquiry Code: 1420 ALLEGED PERSONAL INJURY -

Follow Up?: N Comm Type: M Micro Nbr: More Comments?: Y
 Letter Code:
 NAVIS-SUBSEQUENT***PREVIOUS CONCERN 106274380***ALLEGED INJURY****
 ATTORNEY LETTER DATED 12/2/96;RECEIVED BY LEGAL ON 1/13/97****
 ORNEY WRITES:
 IENT WAS INJURED WHEN SEAT BELT SHE WAS WEARING BROKE IN HALF.
 -HELP F3-EXIT F4-CMTS F5-ADD F6-UPD F9-CLS F10-CRN UP F11-REGN UP F12-INFO UP
 053 REQUESTED CONTACT DISPLAYED LPORA211



st Name: [REDACTED] VIN: 1ZVPT20C3M5 [REDACTED]
me Phone: [REDACTED] Bus. Phone: [REDACTED] Ext:
aler: FREEWAY FORD INC Dist/Reg: 58

CONTACT NBR: 107996748 Date: 01/21/1997 Analyst Code: 1729DH
le Type: INQ Time: 09:27:32 Analyst Name: HOWERY
mm Type: U UPDATE Micro: Letter Code:

Comments: More?: N
REMANDS THAT FORD FURNISH ATTORNEY WITH THE NAMES AND ADDRESSES OF ALL PERSON
COMPANIES KNOWN TO BE IN THE CHAIN OF MANUFACTURE AND DISTRIBUTION OF THE
DESCRIBED DEFECTIVE PRODUCT.

A MADE OBC TO ATTORNEY OFFICE AND SPOKE WITH SEC ON 1/14/97, 1/16/97 AND
AIN ON 1/17/97, FINALLY GETTING VIN IN ORDER TO DOCUMENT LETTER
ADVISED SECRETARY/ANNE THAT THE ATTORNEY'S LETTER WOULD BE FORWARDED TO THE
PROPRIATE OFFICE AND THE ATTORNEY WOULD BE RECONTACTED
O TIME FRAME.

=HELP F3=EXIT F5=ADD F7=PREV F8=NEXT F11=CANC LTR F12=BASIC INFO
002 REQUESTED INFORMATION DISPLAYED LPORA211

**Veronica
Casey**
Law Offices

T.C.
701 Fourth Ave. S., Suite 500
Minneapolis, MN 55415
Phone 337-9526
Fax 337-9052
(612)

Veronica Casey, Attorney at Law

Ann Speltz, Legal Assistant
Lari Havener, Legal Assistant
Barbara Jellich, Legal Assistant

December 2, 1996

DEC 09 1996

Ford Motor Company
Attn: Customer Service
Recall Division
P.O. Box 1904
Dearborne, MI 48121-1904

97 JAN 13 1122A

CONSUMER AFFAIRS
SECTION

Re: Our Client: [REDACTED]
Our File No: 4391
Date of Accident: 11/06/96

Dear Ford Motor Company:

You are hereby placed on notice pursuant to Minn. Stat. Sec. 604.04 of a possible claim against you for a defective product manufactured and distributed by Ford Motor Company.

On or about November 6, 1996, at or near the intersection of [REDACTED] and [REDACTED] Minnesota, Hennepin County, [REDACTED] was injured when the seat belt she was wearing broke in half. She was a driver in a 1991 Ford Probe which was owned by her.

She can seek damages against your company in an amount in excess of \$50,000.00.

You are required by Minn. Stat. Sec. 604.04 to furnish us with the names and addresses of all persons or companies you know to be in the chain of manufacture and distribution of the above described defective product.

Ford Motor Company
November 19, 1996
Page Two

All questions arising from this incident or in connection with the
name should be directed to the undersigned.

Sincerely,



Veronica Casey

VC/jch

Enclosure

cc: [REDACTED]

Veronica
Casey
Law Offices

701 Seventh Ave. S., Suite 500
Minneapolis, MN 55415



Ford Motor Company
Attn: Customer Service
Recall Division
P.O. Box 1904
Dearborne, MI 48121-1904

48121-1904



I got this on 1/20/98



109369487
Jug 14W

DEALER REQUEST FOR CONSUMER AFFAIRS REVIEW

***** FOR DEALER USE ONLY *****

Requesting Dealer: TYSONS FORD P&A: 00012 Region: WASH

Contact Person: RICK SWARTZ Phone No.: 703 448-0100

New or Used Date of Purchase: _____ Yr / Make: 90 PRODL Mileage: 63000 +

VIN: 1ZVPT21U4LS [REDACTED]

Customer Name: [REDACTED]

Address: [REDACTED]

ARLINGTON, VA.

Home Phone: [REDACTED] Business Phone: [REDACTED]

Incident Involves: Accident Fire _____ Warranty _____ Sudden Acc _____

If customer is alleging product defect, what type: SEAT BELT MALFUNCTION

Personal injury? YES Was medical attention sought? YES

Was a police report filed (where)? YES

Name and phone of owner's insurance company (agents name):
ALLSTATE [REDACTED]

Has the insurance company been contacted? YES

If the vehicle is a conversion unit, name of body builder: _____

Accident details (date, where, how, etc.): _____

CUSTOMER REAR-ENDED ANOTHER VEHICLE

What is the customer requesting?: VEHICLE HAD RECALL #96548 #96599
CUSTOMER CLAIMS SEAT BELT DID NOT RETAIN HEAL,
RESULTING IN BACK INJURY.

8/99

IF NEEDED, PROVIDE ADDITIONAL COMMENTS ON A SEPARATE SHEET OF PAPER.

Fax to: (313) 446-9471

PLEASE USE THIS SHEET AS ORIGINAL AND DUPLICATE AS NEEDED

ISOR0062

MORS I Inquiry Contact

01/21/1998 08:22:40

WASHINGTON 27 Zn/Tr: F1 M/A: CONTACT NBR: 109369487 Opened: 01/21/1998
 /IN: 1ZVPT21U4L5 *SCOR 000 Analyst: 7020RH Closed: 01/21/1998
 Last Name: [REDACTED] First Name: [REDACTED] Status: CLOSED
 Title: [REDACTED] MI:
 Address: [REDACTED]
 City: ARLINGTON ST/PV: VA Zip/PC: [REDACTED] CC: USA
 Home Phone: [REDACTED] Business Phone: [REDACTED] Ext:
 Year: 90 Model: PROBE
 Mileage/Km: 62000 WSD: 02/28/1990
 Dealer Name: KIP KILLMON'S TYSONS F SALES CODE: 127014 P&A: 00012
 Causal Code: Symptoms:
 Inquiry Code: 1420 ALLEGED PERSONAL INJURY -

Follow Up?: N Comm Type: F Micro Nbr: More Comments?: Y
 Letter Code:

F1=HELP F3=EXIT F4=CMTS F5=ADD F6=UPD F9=CLS F10=CRN UP F11=REGN UP F12=INFO UP
 I053 REQUESTED CONTACT DISPLAYED LPORB52





Office of the General Counsel

Ford Motor Company
Parklane Towers West
Suite 400
Three Parklane Boulevard
Dearborn, Michigan 48128-2368

February 9, 1998

[REDACTED]
Arlington, VA [REDACTED]

Dear [REDACTED]

We acknowledge your recent contact to Ford Motor Company. Your complaint has been directed to this office for further handling. In order to assist us in evaluating your claim, we request that you provide us with the following information:

1. The date of incident and the city and state in which it occurred.
2. A complete description of the incident, including events which occurred prior to and subsequent to the loss.
3. A copy of the police and/or fire report.
4. For each person alleged injured: full name, date of birth, home address, marital status and name of spouse, social security number, occupation, a complete description of the injuries, the names and addresses of all treating physicians, and copies of all medical bills and reports.
5. The vehicle year, model, and serial number.
6. The mileage on the vehicle at the time of the incident.
7. Original photographs of the vehicle's damage, from several different angles, or color laser copies.
8. Original photographs of the inside of the vehicle showing the steering wheel, dash and roof areas.
9. Original photographs of the accident scene showing the grade of the road.
10. What is the alleged defect?
11. Documentation to substantiate your defect allegation, including a copy of your expert's report and the expert's original photographs.
12. Has the alleged defective part been repaired or replaced?
13. The present location of the alleged defective part and the vehicle.
14. The repair estimate, repair order, or your total loss worksheet for the vehicle's damage, and copies of draft payments.
15. A complete service history for the subject vehicle, including any tune-ups or oil changes.
16. List any after market additions or modifications that were made to the vehicle.
17. We will be pleased to conduct non-destructive testing on your alleged defective part should you choose to remove the part and assembly and ship it at your own expense. Please follow the directions listed in the attached shipping instructions.

- 18. Lost wage verification (if applicable).
- 19. Was the parking brake applied?
- 20. Was the engine running?
- 21. Were the keys in the ignition?
- 22. Has any insurance company been advised of this incident? If so, please state the name, address, and telephone number of those insurance companies; their claim number; and the agent's name.
- 23. If an attorney has been retained by you to settle this claim, please include his/her name, telephone number, and address.
- 24. If this vehicle was purchased as used by the insured please provide: the date of purchase, mileage at the time of purchase, and from whom the vehicle was purchased.
- 25. Other:

Once we are in receipt of the requested information, it will be reviewed and you will be notified of our decision concerning your claim. Should you not send all of the requested information and materials within 45 days, we will assume that you are not interested in pursuing a claim and we will close our file.

Please be advised that all necessary steps must be taken to ensure that the subject vehicle and all of its component parts are maintained and preserved for trial. Ford Motor Company has the right to inspect the vehicle and remove and test any component part that you claim to be defective, and to be presented with the vehicle and the subject component part(s) at the time of trial, should litigation ensue from this informal claim.

If you propose to repair the vehicle for continued usage, such repairs may not be performed until after Ford Motor Company has inspected the vehicle and removed and tested any component part you claim to be defective or advised you in writing that it does not intend to perform such inspection and/or testing at this time. But even in that event, Ford Motor Company will insist that all components claimed to be defective are maintained and preserved for trial.

Sincerely,

Shawn L. Norton
Claims Analyst

dmb

1:\Sales\New\all\lms.v23

==>

ENTER VIN ==> 1ZVPT21U4L5

NAME ==> ZIP ==> MODEL YR ==>

OWNER NAME :
STREET ADDR :

CITY : MILTON

N/A DATE: 96-03-12

ST/PRV: NY CTRY:

ZIP/POSTAL CODE: 12547

N/A SOURCE: R

MODEL YEAR : 90 PLANT: 5

SALE DATE: 90-02-28

BODY STYLE DESC: LX

PRODUCTION DATE: 89-11-29

VEHICLE DESC : 1990 PROBE

	DIVISION	DISTRICT	ZONE	DEALER	PDC CODE	FCSD REGION
SHIP-TO	1	13	F	069	23	13
FACING	1	13	F	069		
RESPONSIBLE	1	13	F	537		

CA EMISSION : ENGINE TAG CODE : AG562AA

CAMPAIGN COUNTS

NAVIS STATUS : 800 COMPANY CAR IND :

TOTAL CAMPAIGNS : 06

DSO DISTRICT : FLEET CODE :

OPEN : 00 CLOSED : 06

DSO NUMBER : FLEET STATUS :

ACTIVE: 05 HISTORY: 01

F1=INQUIRY F3=EXIT F4=G160 F5=G150 F6=CONTINUE SEARCH F9=G130

OGDB166

==> ENTER CAMPAIGN NUMBER==> 92E21 VIN==> 1ZVPT21U4L5 TYPE OF SEARCH: A
 MODEL YEAR: 90 DEFECT: THRT POS SEN BODY STYLE: LX

NEW STATUS CODE: _ CAMP DIV : 6
 REPAIR INFORMATION: TYPE CODE: _ SUPP CODE :
 REPAIR DATE: _ DEALER P/A: _ KIT CODE : AA
 MICRO REF: _ CLAIM NUM: _ OASIS DATE : 92-05-01

DELETE REASON: _ VENDOR N/A INFORMATION:
 RESP DEALER INFORMATION: NEW: _ _ _ IND: MATCH CODE: 4
 CURRENT: 1 13 537 ASSIGNED: 96-03-25 SOURCE: FX EXTRACT DATE: 95-01-23

***** STATUS INFORMATION: ***** REPAIR INFORMATION: *****

CODE	DESCRIPTION	DATE	TYPE	DATE	P/A	CLAIM#	MICRO#	CL	SRC
C	COMPLETE	92-07-03	B	92-06-26	03782		KSS0624	AC	
M	RELEASED FOR MAILING	92-05-01							
H	AWAITING MAILING	92-02-04							

DELETE REASON:

F1=INQUIRY F2=G140 F3=EXIT F5=G130 F7=FIRST F8=NEXT F9=MORE STATUS

F10=ADD STATUS F11=REVISE

I037-NO MORE DATA TO DISPLAY

OGDB166

ENTER CAMPAIGN NBR ==> 92E21 VIN ==> 1ZVPT21U4L5 [REDACTED]
 DEFECT : THRT POS SEN BODY STYLE DESC: LX
 RESP DEALER : 113069 BEGINNING MAILED DATE: 92-06-18
 RELEASE DESC : NI PART & INVOLVED ENDING MAILED DATE : 92-06-18
 CAMPAIGN DIV : 6 FLEET CODE: FLEET MGMT LOC CODE:
 LAST NAME : [REDACTED] INITIALS: [REDACTED]
 STREET ADDR1 : [REDACTED]
 ADDR2 : ST/PRV: NY
 CITY : PORT CHESTER CTRY:
 ZIP/POSTAL CODE: [REDACTED] N-A SOURCE: N N-A EFF DATE: 90-03-02

RESP DEALER : BEGINNING MAILED DATE:
 RELEASE DESC : ENDING MAILED DATE :
 CAMPAIGN DIV : FLEET CODE: FLEET MGMT LOC CODE:
 LAST NAME : INITIALS:
 STREET ADDR1 :
 ADDR2 : ST/PRV:
 CITY : CTRY:
 ZIP/POSTAL CODE: N-A SOURCE: N-A EFF DATE:

F1=INQUIRY F3=EXIT F4=QUIT F5=G150 F7=FIRST PAGE F8=NEXT PAGE F9=G140
 I048-LAST PAGE OGDB166

ENTER CAMPAIGN NUMBER=> 94E54 VIN=> 1ZVPT21U4L9 [REDACTED] TYPE OF SEARCH: A
MODEL YEAR: 90 DEFECT: CATALYST BODY STYLE: LX
NEW STATUS CODE: _____ CAMP DIV : 6
REPAIR INFORMATION: TYPE CODE: _____ SUPP CODE :
REPAIR DATE: _____ DEALER P/A: _____ KIT CODE : AA
MICRO REF: _____ CLAIM NUM: _____ OASIS DATE : 95-02-01
DELETE REASON: _____ VENDOR N/A INFORMATION:
RESP DEALER INFORMATION: NEW: _____ IND: MATCH CODE: 4
CURRENT: 1 13 537 ASSIGNED: 96-03-25 SOURCE: PX EXTRACT DATE: 95-01-23

***** STATUS INFORMATION: ***** REPAIR INFORMATION: *****

CODE	DESCRIPTION	DATE	TYPE	DATE	P/A	CLAIM#	MICRO#	CL	SRC
C	COMPLETE	95-03-16	B	95-03-13	03602	102288	ZRK1586		AC
M	RELEASED FOR MAILING	95-02-01							
H	AWAITING MAILING	95-01-13							

DELETE REASON:
F1=INQUIRY F2=G140 F3=EXIT F5=G130 F7=FIRST F8=NEXT F9=MORE STATUS
F10=ADD STATUS F11=REVISE
I037-NO MORE DATA TO DISPLAY OGDB166

=>

ENTER CAMPAIGN NBR ==> 94E54 VIN ==> 1ZVPT21U4L5 [REDACTED]
 DEFECT : CATALYST BODY STYLE DESC: LX
 RESP DEALER : 113069 BEGINNING MAILED DATE: 95-02-24
 RELEASE DESC : NI PART MDLYR LINE ENDING MAILED DATE : 95-02-24
 CAMPAIGN DIV : 6 FLEET CODE: FLEET MGMT LOC CODE:
 LAST NAME : [REDACTED] INITIALS: [REDACTED]
 STREET ADDR1 : [REDACTED]
 ADDR2 : ST/PRV: NY
 CITY : MILTON CTRY:
 ZIP/POSTAL CODE: [REDACTED] N-A SOURCE: R N-A EFF DATE: 95-02-17

RESP DEALER : BEGINNING MAILED DATE:
 RELEASE DESC : ENDING MAILED DATE :
 CAMPAIGN DIV : FLEET CODE: FLEET MGMT LOC CODE:
 LAST NAME : INITIALS:
 STREET ADDR1 :
 ADDR2 : ST/PRV:
 CITY : CTRY:
 ZIP/POSTAL CODE: N-A SOURCE: N-A EFF DATE:

F1=INQUIRY F3=EXIT F4=QUIT F5=G150 F7-FIRST PAGE F8-NEXT PAGE F9=G140
 K048-LAST PAGE OCDB166

==>

ENTER CAMPAIGN NUMBER==> 95B70 VIN==> 1ZVPT21U4L5 [REDACTED] TYPE OF SEARCH: A
MODEL YEAR: 90 DEFECT: WIRE HARNESS BODY STYLE: LX

NEW STATUS CODE: _
REPAIR INFORMATION: TYPE CODE: _
REPAIR DATE: _____ DEALER P/A: _____
MICRO REF: _____ CLAIM NUM: _____

CAMP DIV : 6
SUPP CODE :
KIT CODE : AA
OASIS DATE : 95-10-10
VENDOR N/A INFORMATION:
IND: Y MATCH CODE:
EXTRACT DATE: 95-07-10

DELETE REASON: _____
RESP DEALER INFORMATION: NEW: _ _ _ _
CURRENT: 1 13 537 ASSIGNED: 96-03-25 SOURCE: PX

***** STATUS INFORMATION: ***** REPAIR INFORMATION: *****

CODE DESCRIPTION	DATE	TYPE	DATE	P/A	CLAIM#	MICRO#	CL SRC
C COMPLETE	96-02-07	B	95-12-29	03602	[REDACTED]	GH00B6B	AC
M RELEASED FOR MAILING	95-10-10						
H AWAITING MAILING	95-07-10						

DELETE REASON:

F1=INQUIRY F2=G140 F3=EXIT F5=G130 F7=FIRST F8=NEXT F9=MORE STATUS
F10=ADD STATUS F11=REVISE

I037-NO MORE DATA TO DISPLAY

OGDB166

=>

ENTER CAMPAIGN NBR ==> 95B70 VIN ==> 1ZVPT21U4L5 [REDACTED]
 DEFECT : WIRE HARNESS BODY STYLE DESC: LX
 RESP DEALER : 113537 BEGINNING MAILED DATE: 95-11-01
 RELEASE DESC : NEW ISSUE TOTAL ENDING MAILED DATE : 95-11-02
 CAMPAIGN DIV : 6 FLEET CODE: FLEET MGMT LOC CODE:
 LAST NAME : [REDACTED] INITIALS: [REDACTED]
 STREET ADDR1 : [REDACTED]
 ADDR2 : ST/PRV: NY
 CITY : MILTON CTRY:
 ZIP/POSTAL CODE: [REDACTED] N-A SOURCE: R N-A EFF DATE: 95-10-10

RESP DEALER : BEGINNING MAILED DATE:
 RELEASE DESC : ENDING MAILED DATE :
 CAMPAIGN DIV : FLEET CODE: FLEET MGMT LOC CODE:
 LAST NAME : INITIALS:
 STREET ADDR1 :
 ADDR2 : ST/PRV:
 CITY : CTRY:
 ZIP/POSTAL CODE: N-A SOURCE: N-A EFF DATE:

F1=INQUIRY F3=EXIT F4=QUIT F5=G150 F7=FIRST PAGE F8=NEXT PAGE F9=G140
 I048-LAST PAGE OGDB166

==>

ENTER CAMPAIGN NUMBER==> 96S48 VIN==> 1ZVPT21U4L5 TYPE OF SEARCH: A
MODEL YEAR: 90 DEFECT: SEAT BELT BODY STYLE: LX

NEW STATUS CODE: _
REPAIR INFORMATION: TYPE CODE: _
REPAIR DATE: _ DEALER P/A: _
MICRO REF: _ CLAIM NUM: _

CAMP DIV : 6
SUPP CODE :
KIT CODE : AA
OASIS DATE : 96-10-03
VENDOR N/A INFORMATION:

DELETE REASON: _
RESP DEALER INFORMATION: NEW: _ _ _
CURRENT: 1 13 537 ASSIGNED: 96-09-19 SOURCE: NI

IND: MATCH CODE:
EXTRACT DATE:

***** STATUS INFORMATION: ***** REPAIR INFORMATION: *****

CODE	DESCRIPTION	DATE	TYPE	DATE	P/A	CLAIM#	MICRO#	CL	SRC
C	COMPLETE	97-08-12	B	97-08-05	00012	593845	IH4MC7H		AC
M	RELEASED FOR MAILING	97-06-09							
M	RELEASED FOR MAILING	96-10-07							
R	READY TO RELEASE	96-09-19							

DELETE REASON:
F1=INQUIRY F2=G140 F3=EXIT F5=G130 F7=FIRST F8=NEXT F9=MORE STATUS
F10=ADD STATUS F11=REVISE
I037-NO MORE DATA TO DISPLAY

OGDB166

==>

ENTER CAMPAIGN NBR ==> 96S48 VIN ==> 1ZVPT21U4L5 [REDACTED]
 DEFECT : SEAT BELT BODY STYLE DESC: LX
 RESP DEALER : 113537 BEGINNING MAILED DATE: 97-06-19
 RELEASE DESC : POSTCARD FOLLOWUP ENDING MAILED DATE : 97-06-19
 CAMPAIGN DIV : 6 FLEET CODE: FLEET MGMT LOC CODE:
 LAST NAME : [REDACTED] INITIALS: [REDACTED]
 STREET ADDR1 : [REDACTED]
 ADDR2 : ST/PRV: NY
 CITY : MILTON CTRY:
 ZIP/POSTAL CODE: [REDACTED] N-A SOURCE: R N-A EFF DATE: 96-03-12

RESP DEALER : 113537 BEGINNING MAILED DATE: 96-10-11
 RELEASE DESC : NEW ISSUE TOTAL ENDING MAILED DATE : 96-10-16
 CAMPAIGN DIV : 6 FLEET CODE: FLEET MGMT LOC CODE:
 LAST NAME : [REDACTED] INITIALS: [REDACTED]
 STREET ADDR1 : [REDACTED]
 ADDR2 : ST/PRV: NY
 CITY : MILTON CTRY:
 ZIP/POSTAL CODE: [REDACTED] N-A SOURCE: R N-A EFF DATE: 96-03-12

F1=INQUIRY F3=EXIT F4=QUIT F5=G150 F7=FIRST PAGE F8=NEXT PAGE F9=G140
 F048-LAST PAGE OGD8166

=>

ENTER CAMPAIGN NUMBER=> 96S99 VIN=> 1ZVPT21U4L5 TYPE OF SEARCH: A
MODEL YEAR: 90 DEFECT: SEAT BELT BODY STYLE: LX

NEW STATUS CODE: _____ CAMP DIV : 6
REPAIR INFORMATION: TYPE CODE: _____ SUPP CODE :
REPAIR DATE: _____ DEALER P/A: _____ KIT CODE : AA
MICRO REF: _____ CLAIM NUM: _____ OASIS DATE : 96-10-07
DELETE REASON: _____ VENDOR N/A INFORMATION:
RESP DEALER INFORMATION: NEW: _____ IND: MATCH CODE:
CURRENT: 1 13 537 ASSIGNED: 96-10-04 SOURCE: NI EXTRACT DATE:

***** STATUS INFORMATION: ***** REPAIR INFORMATION: *****

CODE	DESCRIPTION	DATE	TYPE	DATE	P/A	CLAIM#	MICRO#	CL	SRC
C	COMPLETE	97-08-12	A	97-08-05	00012	593845	1H4HC7H		AC
M	RELEASED FOR MAILING	97-06-09							
M	RELEASED FOR MAILING	96-10-07							
R	READY TO RELEASE	96-10-04							

DELETE REASON:
F1=INQUIRY F2=G140 F3=EXIT F5=G130 F7=FIRST F8=NEXT F9=MORE STATUS
F10=ADD STATUS F11=REVISE
F037-NO MORE DATA TO DISPLAY

OGDB166

ENTER CAMPAIGN NBR ==> 96S99 VIN ==> 1ZVPT21U4L5151835
 DEFECT : SEAT BELT BODY STYLE DESC: LK
 RESP DEALER : 113537 BEGINNING MAILED DATE: 97-06-19
 RELEASE DESC : POSTCARD FOLLOWUP ENDING MAILED DATE : 97-06-19
 CAMPAIGN DIV : 6 FLEET CODE: FLEET MGMT LOC CODE:
 LAST NAME [REDACTED] INITIALS: [REDACTED]
 STREET ADDR1 [REDACTED]
 ADDR2 : ST/PRV: NY
 CITY : MILTON CTRY:
 ZIP/POSTAL CODE: [REDACTED] N-A SOURCE: R N-A EFF DATE: 96-03-12

RESP DEALER : 113537 BEGINNING MAILED DATE: 96-10-11
 RELEASE DESC : NEW ISSUE TOTAL ENDING MAILED DATE : 96-10-16
 CAMPAIGN DIV : 6 FLEET CODE: FLEET MGMT LOC CODE:
 LAST NAME [REDACTED] INITIALS: [REDACTED]
 STREET ADDR1 [REDACTED]
 ADDR2 : ST/PRV: NY
 CITY : MILTON CTRY:
 ZIP/POSTAL CODE: [REDACTED] N-A SOURCE: R N-A EFF DATE: 96-03-12
 F1=INQUIRY F3=EXIT F4=QUIT F5=G150 F7=FIRST PAGE F8=NEXT PAGE F9=G140
 1048-LAST PAGE OGD8166

ENTER CAMPAIGN NBR ==> 91E08 VIN ==> 1ZVPT21U4L5 [REDACTED]
 DEFECT : _____ BODY STYLE DESC: _____
 RESP DEALER : _____ BEGINNING MAILED DATE: _____
 RELEASE DESC : _____ ENDING MAILED DATE : _____
 CAMPAIGN DIV : _____ FLEET CODE: _____ FLEET MGMT LOC CODE: _____
 LAST NAME : _____ INITIALS: _____
 STREET ADDR1 : _____
 ADDR2 : _____ ST/PRV: _____
 CITY : _____ CTRY: _____
 ZIP/POSTAL CODE: _____ N-A SOURCE: _____ N-A EFF DATE: _____

RESP DEALER : _____ BEGINNING MAILED DATE: _____
 RELEASE DESC : _____ ENDING MAILED DATE : _____
 CAMPAIGN DIV : _____ FLEET CODE: _____ FLEET MGMT LOC CODE: _____
 LAST NAME : _____ INITIALS: _____
 STREET ADDR1 : _____
 ADDR2 : _____ ST/PRV: _____
 CITY : _____ CTRY: _____
 ZIP/POSTAL CODE: _____ N-A SOURCE: _____ N-A EFF DATE: _____

F1=INQUIRY F3=EXIT F4=QUIT F5=G150 F7=FIRST PAGE F8=NEXT PAGE F9=G140
 E504-CAMPAIGN FOR THIS VIN NOT FOUND OGDB166

PART NO	CD	COUNT
		3
14529	42	1
14677		1
19712	77	1
38436	56	1
5E212	0B	1
58-DED	42	1
720124		1
721410		1
723942		1
9B989	ND	1
9E731		1
9E731	46	1

PART NO	CCC	COUNT
14529	G05	3
14677		1
19712	C05	1
3B436	M02	1
5R212	A99	1
50-DED	A99	1
720124		1
721410		1
723942		1
9B989	D03	1
9R731		1
9E731	G25	1

NUMBER	PART DESCRIPTION	COUNT	CD DESCRIPTION	COUNT	CUSTOMER CONCERN CODE DESCRIPTION (CCC)	COUNT
		3	MISSING CODE	8	MISSING CODE	8
9E731	SENSOR SPEED ASY	2	42-DOES NOT OPERAT	2	A99-ADMINISTRATIVE (PARTS RETURN,MISBLT)	2
14529	SWITCH ASY-WINDOW R	1	NO	1	C05-AIR CONDITIONER-DOES NOT WORK PROPER	1
14677	RELAY ASSEMBLY	1	08	1	D01-ENGINE DIFFICULT OR SLOW TO START	1
19712	CORE ASY A/C COND	1	46-BURNED OUT	1	G05-WINDOW OPENING, CLOSING TROUBLES-MAN	1
3B436	SHAFT & JOINT ASY	1	56-NOISE/RATTLE/SQ	1	G25-DOES NOT OPERATE PROPERLY(GAGE/INST)	1
5E212	CONVERTER CATALYTIC	1	77-FAILED GASKET	1	ND2-NOISE-UNDER HOOD/FRONT OF VEHICLE	1
5D-DED	ESP / \$50 DED	1				
720124	DOOR ASY-FRONT	1				
721410	GL&CHNL-FR DR WDO	1				
723942	FNL ASY-FT DR TRIM	1				
9B989	THROTTLE POSITION S	1				

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*****
* CLAIMS LISTING FOR 1990 MODEL [REDACTED] REQUESTED BY: [REDACTED] 13JAN98 C/O *
* SORTED BY: PLMTCODE SERIALNO MILESHI DATA SOURCE: PEMS SE-11 *
*****

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*****
* SUMMARY
*
* TOTALS * RATIOS
*
* CLAIMS CLAIMS CLAIMS MATERIAL TOTAL * CLAIMS CLAIMS CLAIMS MATERIAL TOTAL PCT CLAIMS *
* CLAIMS W/COMMENTS IN TIS VEHICLES DEALERS COST COST * PER VENC PER DELR TOTL/SAMP COST/REP COST/REP W/COMMENTS *
* 15 7 15 1 3 $1,085.09 $2,031.07 * 15.00 5.00 0.00 $72.34 $135.40 47% *
*
*****

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CLAIMS LISTING TITLE ABBREVIATIONS

SERIAL NUMBER	CAR LINE	B/S	ETS CCI	PLT NAM	PROD DATE	WARR DATE	SELL DEALR	CLAIM NUMBER	MICRO NUMBER	C S	MCC	PART NUMBER	CC	CCC	CD	REPR DATE	T IS	TACT CODE	MILES	MATL. COST	TOTL COST	LR HRS	REPR DEALR	ST
123456	ESC	3GT	JDM	WAY	07NOV89	03FEB90	11111	123456	JHP34001	7FD4	17A553	46	C05	46	23SEP90	8*	906	10189	11.25	122	0.1	12345	MI	

CARD SEQUENCE NO.-->
 CONCERN CODE (OLD CONDITION CODE)-->
 <--SAMPLE INDICATOR (YES,NO) CUSTOMER CONCERN CODE-->
 CONDITION CODE-->
 TIME IN SERVICE--> <-- ACTUAL ODOMETER READING
 <--TRANSACTION CODE-PRE PAYMENT EDIT

<-- ENGINE CODES--> A = 2.3EFI C = 2.2EFI (PROBE) D = 2.5CFI E = 5.0EFI-HD F = 5.0EFI G = 5.0VV (POLICE) H = 1.3EFI (FESTIVA) J = 1.9EFI-HD L = 2.2EFI-TURBO PROBE R = 3.0EFI-SUPERCHARGE	<-- TRANSMISSION CODES--> A = AXOD B = ATK (BATAVIA) D = MTX (5 SPEED) K = ATK (MAZDA) L = A4LD N = ATK (3 SPD FESTIVA) T = AOD W = MTX (5 SPD PROBE) X = ATK 4SP (AUTO-PROBE) 2 = 5 SPEED (TS-MUSTANG) 4 = ATK (ALL-WHEEL DRV) 5 = 5 SPEED (SUPRCP/XR7) 6 = MTX (5 SPEED SHO)	<-- IF THIS ASTERISK APPEARS THEN CLAIM IS NOT USED IN TIS MATRIX. ('CLAIMS IN TIS' TOTAL (IN SUMMARY ABOVE) EQUALS TOTAL CLAIM COUNT MINUS ASTERISK TIS CLAIMS)
---	---	--

***** 1990 MODEL YEAR PASSENGER CAR BODY DESCRIPTIONS *****				***** 1990 MODEL YEAR PASSENGER CAR BODY DESCRIPTIONS *****			
VEHICLE	BODY DESCRIPTION			VEHICLE	BODY DESCRIPTION		
MUSTANG (MUS)	2LX	2 DOOR	STNDRD LX	3LX	3 DOOR	LX	
	2CG	2 DOOR	CONVRT GT	3GT	3 DOOR	GT	
	2CL	2 DOOR	CONVRT LX				
PROBE (PRB)	3GL	3 DOOR	GL	3LX	3 DOOR	LX	
	3GT	3 DOOR	GT				
ESCORT (ESC)	3-P	3 DOOR	PONY GT	FESTIVA (FES)	3-L	3 DOOR	L
	3GT	3 DOOR	GT		3LP	3 DOOR	L PLUS
	WLX	STATION WAGON	LX		3LX	3 DOOR	LX
	3LX	3 DOOR	LX				
	5LX	5 DOOR	LX				
TEMPO (M)	2GL	2 DOOR	GL	TOPAZ (TOP)	2GS	2 DOOR	GS
	2-G	2 DOOR	GL SPORT		2XR	2 DOOR	XR5
	4GL	4 DOOR	GL		4GS	4 DOOR	GS
	4LX	4 DOOR	LX		4LS	4 DOOR	LS
	4-G	4 DOOR	GL SPORT		4LT	4 DOOR	LTS
	4AM	4 DOOR	AMD		2AX	2 DOOR	AMD XR5
					2AG	2 DOOR	AMD GS
					4AG	4 DOOR	AMD GS
					4AL	4 DOOR	AMD LS
					4AT	4 DOOR	AMD LTS
NOTE: AMD - ALL WHEEL DRIVE							
TAURUS (TAR)	4-B	4 DOOR	BASE	WGL	STATION WAGON	GL	
	4PL	4 DOOR	POLICE	WLX	STATION WAGON	LX	
	4SH	4 DOOR	ALOCK SHO				
	4-G	4 DOOR	GL	SABLE (SAB)	4GS	4 DOOR	GS
	4LX	4 DOOR	LX		4LS	4 DOOR	LS
	4BL	4 DOOR	ALOCK BASE		4GL	4 DOOR	ALOCK GS
	4GL	4 DOOR	ALOCK GL		4LL	4 DOOR	ALOCK LS
	4LL	4 DOOR	ALOCK LX		WGS	STATION WAGON	GS
	W-B	STATION WAGON	BASE		WLS	STATION WAGON	LS
T-BIRD (TBD)	2-B	2 DOOR	BASE	COUGAR (COR)	2LS	2 DOOR	LS
	2LX	2 DOOR	LX		2XR	2 DOOR	ALOCK XR7
	2SC	2 DOOR	ALOCK SC		3LL	3 DOOR	ALOCK LS
	2BL	2 DOOR	ALOCK BASE		ALOCK = EQUIPPED WITH 4-WHEEL ANTI-LOCK DISC BRAKES.		
	2LL	2 DOOR	ALOCK LX				
FORD CROWN	4-S	4 DOOR	S	WCH	WAGON-SQUIRE	LX	
VICTORIA (FRD)	4-L	4 DOOR	BASE	4PL	4 DOOR	POLICE	
	4LX	4 DOOR	LX				
	WSL	WAGON-STEEL	S	MERCURY GRAND	4GS	4 DOOR	GS
	WSH	WAGON-STEEL	BASE		4LS	4 DOOR	LS
	WSH	WAGON-STEEL	LX	MARQUIS (MRC)	WGS	STATION WAGON	BASE
	WCM	WAGON-SQUIRE	BASE		WLS	STATION WAGON	LS
LINCOLN TOWN CAR (LNC)	4-L	4 DOOR	BASE	4LL	4 DR	ALOCK	BASE
	4-S	4 DOOR	SIGNATURE	49L	4 DR	ALOCK	SIGNATR
	4DC	4 DOOR	CARTIER	4DL	4 DR	ALOCK	CARTIER
MARK VII (MK7)	2DB	2 DOOR	BLASS	CONTMTL (CON)	4-L	4 DOOR	BASE
	2BC	2 DOOR	LSC		4-S	4 DOOR	SIGNATURE

***** 1990 LIGHT TRUCK BODY DESCRIPTIONS *****				***** 1990 LIGHT TRUCK BODY DESCRIPTIONS *****			
VEHICLE	BODY DESCRIPTION			VEHICLE	BODY DESCRIPTION		
F-SERIES 4X2 (FS2)	15F	150 L.DUTY	CONV.	35S	350 H.DUTY	SUPR	
4X4 (FS4)	25F	250 L.DUTY	CONV.	35C	350 H.DUTY	CREW	
	2HF	250 H.DUTY	CONV.	45Z	450 H.DUTY	CONV	
	35F	350 H.DUTY	CONV.				
	15S	150 L.DUTY	SUPER	BRONCO (BRO)	B-L	BASE	4X4
	25S	250 L.DUTY	SUPER		BLT	XLT	4X4
	2HS	250 H.DUTY	SUPER		BER	EDDIE BAUER	4X4
VEHICLE	BODY	DESCRIPT	BODY	DESCRIPT	DRIVE CODES		
RANGER	COM	CONV CAB	SUP	SUPER CAB	(RA2) = 4X2 (RA4) = 4X4		
BRONCO II	B-L	BASE	BES	EDDIE BAUER	(B22) = 4X2 (B24) = 4X4		
	XL	XL	XLT	XLT			
AEROSTAR 4X2 (AR2)	<---	REGULAR BODY	<---	<---	EXTENDED BODY <---		
4X4 (AR4)	RWL	WINDOW WAGON	BASE	SWL	WINDOW WAGON		
	RWM	WINDOW WAGON	XL	SWM	WINDOW WAGON XL		
	RWH	WINDOW WAGON	XLT	SWH	WINDOW WAGON XLT		
	RWE	EDDIE BAUER	WAGON	SWE	EDDIE BAUER WAGON		
	RCL	CARGO VAN	BASE	SCL	CARGO VAN BASE		
	RCM	CARGO VAN	XL	SCM	CARGO VAN XL		
	RVL	WINDOW VAN	BASE	SVL	WINDOW VAN BASE		
	RVM	WINDOW VAN	XL	SVM	WINDOW VAN XL		
***** 1990 ECONOLINE/CLUB WAGON *****				***** 1990 ECONOLINE/CLUB WAGON *****			
VEHICLE	BODY	DESCRIPTION		VEHICLE	BODY	DESCRIPTION	
(ECW)	<---	ECONOLINE	<---	<---	CLUB WAGON	<---	<---
	1HL	150 HINGED	DOOR BASE	CHL	150 HINGED	DOOR	BASE
	1HM	150 HINGED	DOOR XL	CHM	150 HINGED	DOOR	XL
	1HH	150 HINGED	DOOR XLT	CHH	150 HINGED	DOOR	XLT
	2HL	250 HINGED	DOOR BASE	DHL	250 HINGED	DOOR	BASE
	2HM	250 HINGED	DOOR XL	DHM	250 HINGED	DOOR	XL
	2HH	250 HINGED	DOOR XLT	DHH	250 HINGED	DOOR	XLT
	3HL	350 HINGED	DOOR BASE	SHL	350 HINGED	DOOR	BASE
	3HM	350 HINGED	DOOR XL	SHM	350 HINGED	DOOR	XL
	3HH	350 HINGED	DOOR XLT	SHH	350 HINGED	DOOR	XLT
	LSL	150 SLIDING	DOOR BASE	CSL	150 SLIDING	DOOR	BASE
	LSM	150 SLIDING	DOOR XL	CSM	150 SLIDING	DOOR	XL
	LSH	150 SLIDING	DOOR XLT	CSH	150 SLIDING	DOOR	XLT
	2SL	250 SLIDING	DOOR BASE	DSL	250 SLIDING	DOOR	BASE
	2SM	250 SLIDING	DOOR XL	DSM	250 SLIDING	DOOR	XL
	2SH	250 SLIDING	DOOR XLT	DSH	250 SLIDING	DOOR	XLT
	3SL	350 SLIDING	DOOR BASE	SSL	350 SLIDING	DOOR	BASE
	3SM	350 SLIDING	DOOR XL	SSM	350 SLIDING	DOOR	XL
	3SH	350 SLIDING	DOOR XLT	SSH	350 SLIDING	DOOR	XLT
	3CL	350 CUTAWAY	BASE				
	3CM	350 CUTAWAY	XL				
	3ST	350 STRIPPED	CHASSIS				

NOTE: IF TIS VALUE HAS (*) THEN CLAIM NOT USED IN TIS MATRIX

VEHICLE INFORMATION						REPAIR INFORMATION																	
SERIAL NUMBER	CAR B/S LNE	ETS CCI NAM	PLT	PROD DATE	WARR DATE	SELL DEALR	CLAIM NUMBER	MICRO C NUMBER	WCC S	PART NUMBER	CC	CCC	CD	REPR DATE	T IS	TACT CODE	MILES	MATL COST	TOTL COST	LBR HRS	RSPR DEALR	ST	
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	102290	CJU26323	8A02	50-DED	42	A99	42	13MAR95	62	255D						
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	013975	HDQ04251	6P05	720124	36		11MAY90	3	1	2067	0.00	-50	15	0.3	03602	NY
** COMMENTS-CLAIM #2 TECH-CUSTOMER STATES DVR DOOR OUT OF ALIGNMENT WITH BODY.																							
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	014751	HYN60951	6C04	723942	67		02AUG90	6	1	2600	0.00	22	0.4	03782	NY	
** COMMENTS-CLAIM #3 TECH-LEFT FRONT DOOR PANEL BESIDE WINDOW BUTTON COMBS UP																							
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	015047	IFV37421	7J05	9E731	42		07SEP90	7	1	2770	41.52	91	0.9	03782	NY	
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	018887	LPOS7141	6H01	721410	56		12SEP91	19	NYL	13355	0.00	24	0.4	03782	NY	
** COMMENTS-CLAIM #5 TECH-CS PASS WINDOW MAKES NOISE ALIGN WINDOW																							
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	018887	LPOS7142	7N09	14577	42		12SEP91	19	NYL	13355	0.00	47	0.8	03782	NY	
** COMMENTS-CLAIM #6 TECH-PASS WINDOW SWITCH LOOSE REPAIR WINDOW SWITCH																							
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	019700	MHM42131	2G02	9B989	L3	D03	NO	02DEC91	22	NYL	16056	26.05	179	2.6	03782	NY
** COMMENTS-CLAIM #7 TECH-CS ENGINE LIGHTS BRIGHT WEEATIC AND CHECK MANUAL SHIFT																							
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	109787	PMA50251	7J05	9E731	46	G25	46	29JUL92	30	807	18114	41.51	106	1.1	03782	NY
** COMMENTS-CLAIM #8 TECH-SPEEDO STAYS AT 0 MPH REPLACE SPEED SENSOR OF REJECTS FROM DWE COMP																							
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	102288	ZRX15861	4C03	5E212	08	A99	08	13MAR95	62	94E5	33800	169.00	229	1.1	03602	NY
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	102290	CJU26321	7H03	19712		C05	77	13MAR95	62	255D	33800	30.24	140	2.0	03602	NY
CLAIM #10 OF 15 TOTAL CLAIMS																							
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	102290	CJU26322	7N09	14529	42	G05	42	13MAR95	62	255D	33800	42.64	59	0.3	03602	NY
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	111436	GHO08680					29DEC95	72	95B7	42030	16.45	44	0.4	03602	NY	
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	557523	TW4KH680	5C05	3B436		N02	56	13FEB96	73	872	43756	702.68	1006	1.4	00012	VA
** COMMENTS-CLAIM #13 CCOM-CUSTOMER COMPLAINS OF FRONT END NOISE AND WAS INFORMED THAT THE NOISE WAS ASSOCIATED WITH CV TECH-437560 R&R BOTH FT AXLE HAFTSHAFT,REPL BOTH FT OUTER CV ROOTS AND OUTER CV JOINTS.																							
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	593845	IN4HC7H0					05AUG97	91	9684	62038	15.00	97	1.0	00012	VA	
151835	PRB	3LX	UXN	FLT	29NOV89	28FEB90	03702	593845	IN4HC7H0					05AUG97	91	9689	62038	0.00	21	0.2	00012	VA	

+ THIS LISTING CONTAINED 15 TOTAL CLAIMS

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* RVP011DC ROOM 10.55.10 PM 10 FEB 1998 RVP011DC*
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*A JOB03818 OGDB166I SYAL ACCTNG OGDB166I JOB03818 A*

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* E N D V P S R6.2 STC: NTVPS E N D *
*****
* JOB/PRINTER ID OFF-PRINTER VPS PRINT STATISTICS *
* JOBNAME: OGDB166I DATE: 1998.041 ELAPSED PRINT TIME: 00.00.03.75 *
* JOBID: JOB03818 02/10/1998 NUMBER LINES PRINTED-----240 *
* PRINTER NAME: RVP011DC TUE AVG COMP LINE LGTH (Q)-----61 *
* VPSLIB MEMBER: RVP011DC TIME: 22.55.10.91 AVG COMP LINE LGTH (V)-----111 *
* SEPINFO: NUMBER PAGES PRINTED-----7 *
* GROUP NAME: NUMBER VTAM SENDS-----40 *
* NUMBER C/S PRINTED-----1 *
* NUMBER STAGING I/O'S-----0 *
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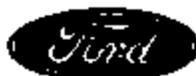
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* START RVP011DC          ROOM          10.55.07 PM 10 FEB 1998 RVP011DC*
*A JOB03818 OGD8155I      SYA1 ACCTNG      OGD8155I JOB03818 A*

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Office of the General Counsel

Ford Motor Company
Parklane Towers West
Suite 400
Three Parklane Boulevard
Dearborn, Michigan 48128-2588

May 15, 1997

[REDACTED]
[REDACTED]
Myrtle Beach, SC [REDACTED]

Re: [REDACTED]

D/A: April 3, 1997

Dear [REDACTED]

I have requested a Design Analysis engineer be assigned to this file for the purpose of inspecting the vehicle. That individual will be contacting you so that arrangements can be made to conduct the inspection. Hopefully this will occur within the next 30 to 60 days.

Sincerely,

Jessie Hollingsworth
Claims Analyst

dmb

http://www-uk.nsa.nsa.gov/odis/odis.html



NSA: Office of Defects Investigation (ODI)

Recall Reports

Call the Auto Safety Hotline at (1-800-424-9393) to report safety defects or to obtain information on car, truck, child seat, highway or traffic safety.

Report Date: Thu Feb 6 09:01:31 1997

NHTSA CAMPAIGN ID Number: 91V016000 - -

Make: FORD

Model: PROBE

Year: 1991

Causing Part: ASSEMBLY IMPROPERLY INSTALLED LOCATION PROPERLY INSTALLED
 Resulting Fault: WELD JOINT BROKEN

Component: INTERIOR SYSTEMS RESTRAINT BELT ANCHOR AND ATTACHMENT

Manufacturer: FORD MOTOR COMPANY

Year of Recall: 1991

Type of Report: Vehicle

Potential Number of Units Affected: 7,700

Summary:

BRACKETS MOUNTING AUTOMATIC SHOULDER BELT RETRACTOR ASSEMBLY MAY HAVE
 WEAKENED STRENGTH IN WELD

SHOULDER BELT COULD BE IN A COLLISION INCREASING RISK OF INJURY TO
 OCCUPANT.

INSTALL TWO BOLTS IN THE BRACKETS TO PREVENT SHOULDER BELT FAILURE

SYSTEM: SAFETY BELT RETRACTOR BRACKET ATTACHMENT.

VEHICLE DESCRIPTION: PASSENGER CARS; PROBE GT MODELS ONLY

NHTSA CAMPAIGN ID Number: 93V015000

In the event of a vehicle collision, the occupant would not be adequately restrained, increasing the risk of personal injury.

Dealers will replace driver side and inoperative passenger side shoulder belt track assemblies. Ford has not developed a remedy plan for passenger side shoulder belt track assemblies that are not functioning properly.

Owner Notification: Owner notification is expected to begin during October 1996.

This search returned 3 records.

Make: FORD

Model: PROBE

Fault: ALL

Comment: ALL

If you would like to do another search on this same make, model and component, but for another model year, please enter that new year in the box below and click on the Resubmit Year button.

Please note that for items where the year is unknown, a date of 1900 is used.

Please enter the new model year:

OR you can do a new search.



Please send corrections or comments about this Web Page to the [NHTSA Web Page Manager](http://www.nhtsa.gov/ncb/).

Make: FORD

Model: PROBE

Year: 1991

Causing Fault: ASSEMBLY, IMPROPERLY INSTALLED LOCATION, PREPARATION

Resulting Fault: DISCONNECTED, PULL OFF, SPARE

Component: BRAKES:HYDRAULIC:SHOE AND DRUM SYSTEM:DRUM

Manufacturer: MIDAS INTERNATIONAL CORP.

Year of Recall: 1991

Type of Report: Equipment

Potential Number of Units Affected: 300

Summary:

THE GROOVE FOR THE REAR WHEEL BEARING BELT OUTER RING WAS INCORRECTLY MACHINED.

IF THE RETAINING RING DOES NOT FIT CORRECTLY IN THE GROOVE, THE AXLE HUB NUTS WILL BREAK, CAUSING THE BRAKE DRUM WHEEL AND THE ASSEMBLY TO SEPARATE FROM THE VEHICLE.

MIDAS SHOPS WILL REPLACE THE BRAKE DRUMS WITH OTHER BRAKE DRUMS FROM ANOTHER SUPPLIER.

SYSTEM: BRAKES:HYDRAULIC:SHOE AND DRUM SYSTEMS:DRUM

EQUIPMENT DESCRIBED IN REPLACEMENT BRAKE DRUMS FOR PASSENGER VEHICLES. MIDAS PART NO. 10155. NOTES: IF YOUR VEHICLE IS PRESENTED TO AN AUTHORIZED DEALER ON AN AGREED TO SERVICE DATE AND THE REMEDY IS NOT PROVIDED WITHIN A REASONABLE TIME AND FREE OF CHARGE OR THE REMEDY DOES NOT CORRECT THE DEFECT OR NONCOMPLIANCE, PLEASE CONTACT THE NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION'S AUTO SAFETY AT 1-800-424-9093 (EMERGENCY) OR 1-800-424-9091, LTD. OF TOKYO, JAPAN MANUFACTURED THESE BRAKE DRUMS. THERE IS A REPRESENTATIVE IN PART OF AMERICA, LOS ANGELES, CA. THESE BRAKE DRUMS WERE INSTALLED ON VEHICLES FROM JULY 12, 1991 THROUGH SEPTEMBER 30, 1991.

NHTSA CAMPAIGN ID Number: 96V172000

Make: FORD

Model: PROBE

Year: 1991

Causing Fault: CHAFF, WEAR EXCESSIVE, NEXT, SCORCH

Resulting Fault: INOPERATIVE

Component: INTERIOR SYSTEMS:SHOULDER BELTS

Manufacturer: FORD MOTOR COMPANY

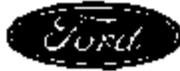
Year of Recall: 1991

Type of Report: Vehicle

Potential Number of Units Affected: 224,000

Summary:

The rail of the automatic shoulder belt can wear sufficiently such that the cable which retracts the buckle assembly will become jammed in the rail rendering the shoulder belt inoperative.



Product Development
Ford Motor Company

Perkins Tower West - Suite 664
Three Perkins Boulevard
Dearborn, Michigan 48128
FAX: 313-337-3256

July 15, 1997

Robert G. Bacon, Esq.
Harry Pavlack & Associates, PA
P. O. Box 2740
Myrtle Beach, S. C. 29578-2740

Reference: [REDACTED] Ford Motor Company

Dear [REDACTED]

[REDACTED] I have been asked to contact you to schedule a vehicle inspection. My office phone number is [REDACTED]

I look forward to working with you.

Sincerely yours,

/ s /
Ralph B. Bell
Design Analysis Engineer

HARRY PAVILACK & ASSOCIATES, PA
ATTORNEYS AT LAW
POST OFFICE BOX 2740
MYRTLE BEACH, SOUTH CAROLINA 29578-2740
(803) 448-9471 * FAX (803) 636-0003

HARRY PAVILACK, SC, FL

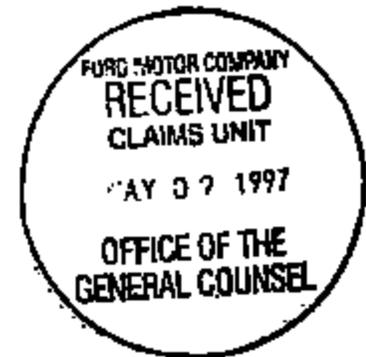
ROBERT S. HAIGHT, JR., P.A., SC
JAMES M. ROBBINS, SC
JEFFREY A. KEENAN, SC
THOMAS A. McDERMOTT, SC, NC, GA

CYNTHIA M. LOVER, SC
MORTON M. GEDDIE, GA
DEBRA S. HARPE, NC
ROBERT G. BACON, SC

VH

✓
400866

May 5, 1997



JESSIE HOLLINGSWORTH
FORD MOTOR COMPANY
PARKLANE TOWERS WEST, SUITE 400
THREE PARKLANE BOULEVARD
DEARBORN MI 48126-2568

RE: **My Client** : [REDACTED]
Contact Number : 108300026
Date of Accident: April 3, 1997

Dear Sir or Madam:

Enclosed are copies of the medicals I have received to date from [REDACTED]. Please document your file and contact me if you have any questions or comments.

Sincerely,

HARRY PAVILACK & ASSOCIATES

RB

Robert G. Bacon

RGB/ns

Enclosures

CONWAY SC

PHONE

EXT

PROVIDER

Name:

DOB:

SS #:

Addr:

CONWAY

SC

Account #: Ticket #: 120101 Date of Service: 04/03/97 RED BLUFF STA
From: 1250 HWY 905 To: LORIS COMMUNITY HOSP.

Diagnosis:

Policy #

Services / Supplies		
L0140 SH	C COLLAR-DISPOSABLE	35.00
A0422 SH	OXYGEN IN CTY	20.00
A0362 SH	ELS BASE RATE	120.00
Total Charges		175.00

Transactions to Date

Balance Due 175.00

NON-AMBULATORY
MOVE BY STRETCHER ONLY

MEDIC [REDACTED]
MEDIC [REDACTED]

[REDACTED]

CAD #975060
GRID 183

04/03/1997

Page #1

PATIENT CARE REPORT

C.A.D #: 975060
Report#: 1 of 2
Date: APR-03-1997

Location: 01250-DWY 205
City: [REDACTED]
LocType: [REDACTED]

Disposition: Hospital #2
Destination: LOUIS CUMMERY HOSP.
Reason: Nearest Hospital
Reason #2: Patient's Request
TypeCode: emergent
ChngDtc: emergent

Arrv: 07:33
Disp: 07:33
Shrt: 07:34
AtCom: 07:39

Station: Red Bluff
Region: [REDACTED]
Shift: A -Shift
Unit Qm: ALS
Param: 0: 03717

EmpCode: emergent
ChngDtc: emergent

Call Type: TRANSPORT

Acce: 07:40

Medic A: [REDACTED]
Medic B: [REDACTED]
Other: [REDACTED]
FrmCode: [REDACTED]
TptAgency: [REDACTED]

RespWch1: LAM
RespWch2: FZM
AssistW1: FZM
AssistW2: MM
Name: [REDACTED]
OpAlayBy: [REDACTED]
TfCode: [REDACTED]
TptType: [REDACTED]

RespMileage: 0.0 - 0.0 = 0.0
TptMileage: 0.0 - 0.0 = 0.0
TptAlayBy: [REDACTED]
CarryTfCode: [REDACTED]
TptUnit: [REDACTED]

Tpct: 08:01
AtDest: 08:18
Clrd: 09:13
Base: 08:18
TptAcc: 1
TptDe: 1

Patient: [REDACTED]
Age: [REDACTED]
Gender: [REDACTED]
Race: [REDACTED]
Weight: 0.68 lbs

Address: [REDACTED]
City: COMBAY
State: SC
Accomp'dBy: [REDACTED]
Effects: [REDACTED]

Country: UNITED STATES
Zipcode: [REDACTED]
Phone: [REDACTED]

Bill to: PATIENT
Guarantor: [REDACTED]
Address: [REDACTED]
City: COMBAY, SC.
Phone: [REDACTED]

Relation: Spouse
SSN: [REDACTED]

Nature of Call: [REDACTED]

Date of Injury: APR-03-1997
Time of Injury: 07:28
CC/RI: [REDACTED]

Mechanism Injury: [REDACTED]
Pertinent Hx: UNKNOWN
Medications: NO KNOWN MEDS.
Allergies: [REDACTED]

TRAVEL: Safety Equipment - Seatbelts

Found: [REDACTED]
Position: [REDACTED]
Transport: HELIX CRT/LAM

Head: [REDACTED]
Neck: [REDACTED]
Chest: [REDACTED]
Abdomen: [REDACTED]
Back: [REDACTED]
Pelvis: [REDACTED]
Upper Extremities: [REDACTED]
Lower Extremities: [REDACTED]

Blood Loss: [REDACTED]
Gchar: [REDACTED]
n/a:
n/a:
n/a:
n/a:
n/a:

VITAL SIGNS

08:01 [REDACTED]

HORRY COUNTY EMS
PATIENT CARE REPORT

CAD #975060
GRID 183

Page #

05/1997
06:12

[REDACTED]

Time: 06:12
DN: 01 148/80
06:12 119/79

Police #400 5402 Cap #4111 805
Normal

Preliminary:
Primary:
Completed by:

[REDACTED]

MEAC 1:
Required G2
Immobilized / pass. FX

Base Contact Information

Time	By	Hospital	EM/Ordering Dr.	Base Contact	Orders	Communication	MOO
06:05	[REDACTED]	[REDACTED]	[REDACTED]	NOTIFIED		VEP	N
06:08	[REDACTED]	[REDACTED]	[REDACTED]	NOTIFIED		VEP	E

Time
07:15
06:05
06:05

[REDACTED]

VIN:
 Last Name:
 Title: MS
 Address:
 City: EDEN
 Home Phone:
 Year: 91
 Mileage/Km:
 Zn/Tr:
 M/A:
 CONTACT NBR: 108300026
 *SCOR 000 Analyst: 3616LW
 First Name:
 ST/PV: NC Zip/PC:
 Business Phone:
 Model: PROBE
 WSD:
 Opened: 04/09/1997
 Closed: 04/09/1997
 Status: CLOSED
 MI:
 CC: USA
 Ext:

Dealer Name:
 Causal Code:
 Inquiry Code: 1420
 SALES CODE:
 Symptoms:
 ALLEGED PERSONAL INJURY -
 P&A:

Follow Up?: N
 Comm Type: P
 Micro Nbr:
 More Comments?: Y
 Letter Code: OGCl

F1=HELP F3=EXIT F4=CMTS F5=ADD F6=UPD F9=CLS F10=CRN UP F11=REGN UP F12=INFO UP
 I053 REQUESTED CONTACT DISPLAYED OGDB112

Last Name: [REDACTED] VIN:
Home Phone: [REDACTED] Bus. Phone: [REDACTED] Ext:
Dealer: [REDACTED] Dist/Reg:

CONTACT NBR: 108300026 Date: 04/09/1997 Analyst Code: 3616LW
File Type: INQ Time: 11:10:39 Analyst Name: WEIPERT
Comm Type: P PHONE Micro: Letter Code: OGCI

Comments: More?: Y

NO VIN AVAILABLE

CUSTOMER SAYS:

- BOYFRIEND CALLING ON BEHALF OF CAR OWNER
- INVOLVED IN A COLLISION, HIT ANOTHER VEHICLE
- CALLER THINKS VEHICLES OWNER HAS CONTACTED INSURANCE COMPANY
- ALLEDGES SEATBELT FAILED TO ENGAGE, ALLEDGES INJURIES WERE SUSTAINED
- MEDICAL ATTENTION WAS SOUGHT
- NAME OF ALLEDGED INJURED PERSON GARY GRUBBS
- DRIVING ALONG AND ANOTHER VEHICLE PULLED OUT IN FRONT OF VEHICLE
- PASSENGER SIDE SEATBELT ALLEDGEDLY DID NOT ENGAGE

F1=HELP F3=EXIT F5=ADD F7=PREV F9=NEXT F11=CANC LTR F12=BASIC INFO

OGDB112

Last Name: [REDACTED]
Home Phone: [REDACTED]
Dealer:

Bus. Phone: [REDACTED]

VIN:
Ext:
Dist/Reg:

CONTACT NBR: 108300026
File Type: INQ
Comm Type: U UPDATE

Date: 04/09/1997
Time: 11:10:42
Micro:

Analyst Code: 3616LW
Analyst Name: WEIPERT
Letter Code:

Comments:

More?: Y

*

PER CUSTOMER, DEALER SAYS:

- NO CONTACT

*

CUSTOMER SEEKS:

- TO INFORM FORD OF THIS

*

CAC ADVISED:

- CREATED CLOSED INQUIREY CODE 1420

- CUSTOMER PROVIDED INVALID VIN NUMBER

F1=HELP F3=EXIT F5=ADD F7=PREV F8=NEXT F11=CANC LTR F12=BASIC INFO

I002 REQUESTED INFORMATION DISPLAYED

OGDB112

Last Name: [REDACTED] VIN:
Home Phone: [REDACTED] Bus. Phone: [REDACTED] Ext:
Dealer: [REDACTED] Dist/Reg:

CONTACT NBR: 108300026 Date: 04/22/1997 Analyst Code: 9681LS
File Type: INQ Time: 13:59:26 Analyst Name: SHEPHEARD
Comm Type: C CALL BACK Micro: Letter Code:

Comments: More?: Y

CUSTOMER SAYS:

- VEHICLE WAS TOTALED
- WILL SEND PICTURES ALONG
- ALLEGES HE WAS SLAMED INTO THE WINDSHIELD BECAUSE THE SEAT BELT DID NOT WORK
*

PER CUSTOMER, DEALER SAYS:

- NO CONTACT
*

CUSTOMER SEEKS:

- RESOLUTION

F1=HELP F3=EXIT F5=ADD F7=PREV F8=NEXT F11=CANC LTR F12=BASIC INFO

1002 REQUESTED INFORMATION DISPLAYED

OGDB112

Last Name: [REDACTED]

VIN:

Home Phone: [REDACTED]

Bus. Phone: [REDACTED]

Ext:

Dealer:

Dist/Reg:

CONTACT NBR: 108300026

Date: 04/22/1997

Analyst Code: 9681LS

File Type: INQ

Time: 13:59:28

Analyst Name: SHEPHEARD

Comm Type: U UPDATE

Micro:

Letter Code:

Comments:

More?: N

*

CAC ADVISED:

- ENCOURAGED CUSTOMER TO SUBMIT INFORMATION TO FORD

F1=HELP F3=EXIT F5=ADD F7=PREV F8=NEXT F11=CANC LTR F12=BASIC INFO

1002 REQUESTED INFORMATION DISPLAYED

OGDB112

HARRY PAVILACK & ASSOCIATES, PA
ATTORNEYS AT LAW
POST OFFICE BOX 2740
MYRTLE BEACH, SOUTH CAROLINA 29578-2740
(803) 448-9471 * FAX (803) 626-0003

HARRY PAVILACK, SC, FL

ROBERT S. HAIGHT, JR., P.A., SC
JAMES M. ROBBINS, SC
JEFFREY A. KEENAN, SC
THOMAS A. McDERMOTT, SC, NC, GA

CYNTHIA M. LOVER, SC
NORTON M. GEDDIE, GA
DEBRA S. HARPE, NC
ROBERT G. BACON, SC

May 2, 1997

JESSIE HOLLINGSWORTH
FORD MOTOR COMPANY
PARKLANE TOWERS WEST, SUITE 400
THREE PARKLANE BOULEVARD
DEARBORN MI 48126-2568

RE: My client : [REDACTED]
Conway, SC [REDACTED]
Date of Birth : March 14, 1961
Marital Status : [REDACTED]
Owner : [REDACTED]
Contact Number : 108300026
Date of Accident: April 3, 1997

Dear Sir or Madam:

Please be advised that I represent [REDACTED] in regard to his personal injury claim of April 3, 1997 in which he was operating his girlfriend's 1991 Probe.

At this time, I am enclosing a copy of the accident report, several pictures of the vehicle depicting the defect in the seatbelt and indicating the crack in the windshield where [REDACTED] head struck, and copies of [REDACTED] medicals I have received to date. [REDACTED] is currently undergoing treatments with Access Medical Center [REDACTED] where he is doing [REDACTED]. As soon as I receive [REDACTED]'s lost wages and additional specials, I will forward copies of same directly to you.

The vehicle has not been repaired and is in the owner's possession. Please document your file and contact me if you have any questions or comments.

Sincerely,

HARRY PAVILACK & ASSOCIATES



Robert G. Bacon

RGB/ns
Enclosures

ORIGINAL
D.R.S. USE ONLY

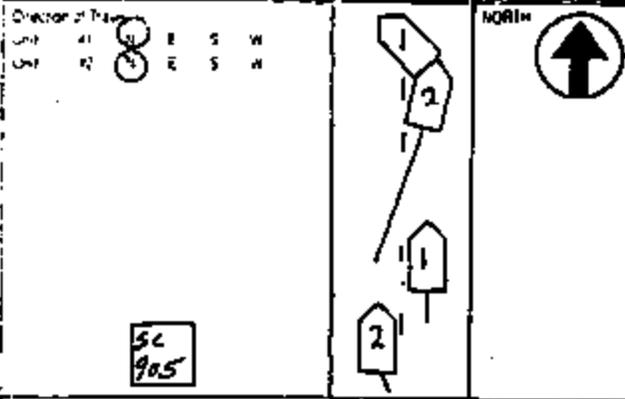
SOUTH CAROLINA
UNIFORM TRAFFIC COLLISION REPORT
DEPARTMENT OF PUBLIC SAFETY
FORM TR-316 (REV. 880)

Amended - Attach Copy of Original Report
Corrected Page 1 of 2
of Units 2

Date 04-03-97	Time 0730	County 26	1- Interstate 2- US Primary 3- SC Primary	4- Secondary 5- County 6- Other	COLLISION LOCATION Route Number and Name if any ON 905	1- Not Liable 2- Liable	AUXILIARY 1- Spill 2- Contaminant 3- Burnout	4- Spill 5- Other
Lane 1	Direction N E S W	Travel Direction N E S W	1- Interstate 2- US Primary 3- SC Primary	4- Secondary 5- County 6- Other	BASE INTERSECTION Route Number and Name if any FROM 347	1- Not Liable 2- Liable	AUXILIARY 1- Spill 2- Contaminant 3- Burnout	4- Spill 5- Other
Distance 1.04 MILES FEET	Direction N E S W	Travel Direction N E S W	1- Interstate 2- US Primary 3- SC Primary	4- Secondary 5- County 6- Other	SECOND INTERSECTION Route Number and Name if any TOWARD 468	1- Not Liable 2- Liable	AUXILIARY 1- Spill 2- Contaminant 3- Burnout	4- Spill 5- Other

City or Town: **Locis** Dr if Outside: **10:00** Unit: **N E S W** D.R.S. USE ONLY: **1854**

Unit # 1	Driver Name Harry Long	City/State Longs SC	Unit # 2	Driver Name Skipper's Only	City/State Conway SC
Vehicle # 92400	Vehicle # 97				
Commercial Vehicle 1- YES 2- NO					
K-142149	K-142150	K-142150	K-142150	K-142150	K-142150



Describe what happened prior to Unit # Number:
Unit #1 + Unit #2 were Northbound on SC-905. Unit #2 was attempting to pass Unit #1. Unit #1, with no brake lights working, made an improper left turn and was struck by a skidding Unit #2.

Unit #1: Allstate
Unit #2: Intrepid 9106355227

NOTICE: This Uniform Traffic Collision Report is for statistical reporting purposes only and should not be used for insurance, damage, and other purposes. The collision report is the property of the Department of Public Safety.

SPECIAL USE ONLY: INTERNAL AGENCY CODE

Damage to Property of Unit 1: **2500** Damage to Property of Unit 2: **3000**

Address: **Longs SC**

OCCUPANTS

NAME	ADDRESS	ZIP
Driver Unit #2		

Investigator's Name: **James-SIA** Agency: **AP0500** Date: **4-4-97** Time: **10:00**

DEPARTMENT OF PUBLIC SAFETY
NOTICE OF REQUIREMENT

Date 04-03-97	Time 0730	County 26	1 - Interstate 2 - US Primary 3 - SC Primary	4 - Secondary 5 - County 6 - Other	ACCIDENT LOCATION Route Number and Name if any 905	AUXILIARY 1 - Main Line 2 - Alternate	3 - Spill 4 - Connection 5 - Business	6 - Bypass 7 - Other
------------------	--------------	--------------	--	--	--	---	---	-------------------------

TO VEHICLE OPERATOR / OWNER:

FAILURE TO COMPLY SHALL RESULT IN APPROPRIATE ACTION UNDER SECTION 56-10-270 OF THE 1976 CODE OF LAWS OF S.C. AS AMENDED, IF VEHICLE SUBJECT TO REGISTRATION IN SOUTH CAROLINA, AND UPON CONVICTION THEREOF, THE DEPARTMENT MUST SUSPEND YOUR DRIVING AND/OR REGISTRATION PRIVILEGES FOR A PERIOD OF THIRTY DAYS AFTER WHICH YOU WILL BE REQUIRED TO FILE PROOF OF FUTURE FINANCIAL RESPONSIBILITY BEFORE REINSTATEMENT.

Unit # 1	Sex M	Race W	Driver License Class SC D	City, State & Zip Horry SC	Unit # 2	Sex M	Race W	Driver License Class SC C	City, State & Zip Conway SC
92407	52	97	52	97	97	20	97	97	97
50 W. Beargrass Rd. Horry County, SC					Conway SC				

NOTICE OF REQUIREMENT ACCEPTED

Signature: *[Signature]*

Operator/Owner refused to file coverage? Yes No
Vehicle subject to registration in SC? Yes No

S.B. James
OFFICER

353 HPO500
BADGE # JURISDICTION CODE

- 1 - CITY POLICE 2 - SHERIFFS DEPT. 3 - COUNTY POLICE 4 - HIGHWAY PATROL 5 - OTHER

TO BE COMPLETED BY INSURANCE AGENT, BROKER OR OTHER INSURANCE COMPANY REPRESENTATIVE

I hereby affirm that to the best of my knowledge the policy described was in effect covering the vehicle

on the date and time as mentioned.

Name of Insurance Company

Policy Number

From

Policyholder

The information as certified herein is based solely upon my knowledge and belief as a representative of the above insurance company and no warranty of liability is imputed to the above mentioned insurance company as I have listed herein.

Signature of Authorized Representative

Title

Company Code Number (Assigned by S.C. Department of Insurance)

(If insurance agent or broker indicate corresponding company code number assigned by the South Carolina Department of Insurance, indicate whether report, broker, etc.)

Area Code and Telephone Number

NOTICE: THIS FORM IS NOT VALID UNLESS IT IS ACCOMPANIED BY THE ORIGINAL CERTIFICATE OF FINANCIAL RESPONSIBILITY ISSUED BY THE SOUTH CAROLINA DEPARTMENT OF PUBLIC SAFETY.

Return to: FORM FR-19
FINANCIAL RESPONSIBILITY
SOUTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
P.O. BOX 1428
COLUMBIA, SOUTH CAROLINA 29216-0042

IF ANY OF THE BELOW ARE APPLICABLE, DETERMINE THE ABOVE PORTION.

- Check here if a Form SR-23, Fleet Policy of 25 or more vehicles is on file with the Department covering the vehicle.
- Check here if a certificate of self-insurance has been issued by the Department covering the vehicle and indicate the certificate number, SI-_____
- Check here if liability insurance was not in effect to comply with South Carolina statutory requirements.

FORM FR-19 NOT ISSUED: SECTION 56-10-270

NO FORM FR-19 ISSUED TO OPERATOR/
OWNER OF UNIT NO. _____
SURVIVAL ISSUED TO _____
SURVIVAL NUMBER _____
FOR OPERATING OR ALLOWING THE OPERATION OF
AN UNINSURED VEHICLE.

Signature

Date

SIGNATURE

K-142143

Company: 911544e
Policy No.: 035 07461
Agency: _____
Area Code & Phone No.: _____



CAROLINA RADIOLOGY, LLC

Billing Office: 1301 Russell St.
P.O. Box 2845
Crawfordsville, SC 29116

FORWARDING AND ADDRESS CORRECTION REQUESTED

IF PAYING BY MASTERCARD OR VISA, FILL OUT BELOW.

CHECK CARD TYPE (PLEASE PRINT)

MASTERCARD VISA

STATEMENT DATE: 04/08/97

PAY THIS AMOUNT: \$106.00

ACCT. # A200002

SHOW AMOUNT PAID HERE \$

Phone: 803-294-5456

ATTN: MR Bacon

ADDRESS

CITY



CORWAY, SC

CHARLESTON, SC

Please check box if above address is correct or otherwise, if corrections have changed, and include change(s) in address only

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT.

DATE	CPT. CODE	ICD-9	DESCRIPTION	CHARGE	PAYMENT
04/03/97	72050	959.1	[REDACTED]	36.00	
04/03/97	72110	959.1	[REDACTED]	44.00	
04/03/97	70210	959.1	[REDACTED]	26.00	

IF YOU WOULD LIKE THIS FILED, CALL OUR OFFICE. PLEASE PAY WITHIN 15 DAYS.

STATEMENT DATE	ACCOUNT NO.	PATIENT NAME	REFERRING PHYSICIAN
04/08/97	A200002	[REDACTED]	[REDACTED]

LOCATION OF SERVICE:

PH BUSINESS OFFICE 1301 RUSSELL, TAX ID 571049603

PLEASE PAY THIS AMOUNT \$106.00

5 L0200002 13
ORIS, SC 001
57-6001328 040397 040397 0 0

CONWAY, SC

3141961 M 5 040397 08 1 7 99 01 M053345 80 C5

1 040397 42 040397

CONWAY SC

270	2	465
320	4	36100
450	1	7100
981	1	26400

001 TOTAL CHARGE 70065 0
00 Y Y

70065

470 8479 9100 9180 E8120
C59180

LORIS
PHON

PATIENT CHART COPY

COUNT NO.	ADMISSION DATE	04/03/97	MEDICAL RECORD NO.
ROOM/BED	ADMISSION TIME	0830	FINANCIAL CLASS
TYPE	LOCATION/SERVICE	EP	S7/
TIENT			SOCIAL SECURITY NO.

NAME	PATIENT
REG 1	DATE OF BIRTH
REG 2	AGE
CITY/STATE/ZIP	SEX
HOME PHONE	RACE
	RELIGION
	MAR. STS.

TIENT EMPLOYER	PERSON TO NOTIFY
NAME	NAME
REG	STREET
CITY/STATE/ZIP	CITY/STATE/ZIP
HOME	EDEN, NC
	PHONE
	REL. F

GUARANTOR	GUARANTOR EMPLOYER
NAME	NAME
REG	STREET
CITY/STATE/ZIP	CITY/STATE/ZIP
HOME	MYRTLE BEACH, SC
	PHONE

INSURANCE	POLICY NUMBER	S	COVERAGE NO.	SUBSCRIBER	REL
-----------	---------------	---	--------------	------------	-----

SELF PAY

ACCIDENT	AUTO ACCIDENT	ATTENDING DR.
ACCIDENT DATE	04/03/97 TIME	ADMITTING DR.
ARRIVAL MODE	AKB	FAMILY DR.
REASON FOR VISIT		NONE

LAST VISIT LAST 48 HOURS	N	MEDICAL POWER	LIVING WILL	PAMPHLET GIVEN	VETERAN
COPIES COLLECTED		COPY MADE	COPY ON FILE	USER	ADN, P, S
START HOSPITALIZATION	FROM	TO	LOG	CHG. DISP.	
CHARGE DATE		TIME			

PRINCIPAL DIAGNOSIS

OPERATIONS

EMERGENCY

DEPARTMENT

FAMILY

L0200002

04/03/97

Room #

A

Patient
 Non-Patient
 Age: [redacted] Sex: [redacted]
 Race: [redacted] DOB: [redacted]
 Primary Care: [redacted] None OCT
 Admitting: [redacted] New +8 yr
 Discharge: [redacted] JTD Disch
 Nurse's Signature: [redacted] Weight: [redacted] Lib: [redacted]

Admitting: [redacted] Date: 4/3/97
 Room: LMP
 Preop: Yes No
 Decon Med
 Urt All
 Accompanied by: self parent

Adult Level: Urgent Non-urgent
 bed Grouped
 Mode of Transportation: ambulatory carried
 wheelchair
 Modifications: none health low
 assist comm other
 Accompanied by: self parent

[Large redacted area]

[Redacted] [Redacted] [Redacted] [Redacted]
 [Redacted] [Redacted] [Redacted] [Redacted]
 [Redacted] [Redacted] [Redacted] [Redacted]

[Redacted] [Redacted] [Redacted] [Redacted]
 [Redacted] [Redacted] [Redacted] [Redacted]
 [Redacted] [Redacted] [Redacted] [Redacted]

Discharge Diagnosis: [redacted]
 Secondary Diagnosis: [redacted]
 Discharge Instructions: [redacted]
 DISCHARGE TEACHING SHEET

[Redacted] [Redacted]
 [Redacted] [Redacted]
 [Redacted] [Redacted]

OUT-PATIENT TREATMENT ONLY and that I may be able before all my medical problems are known or treated. I arrange for follow-up care as instructed above. I also understand that X-RAYS or EKG's done will be reviewed by a Radiologist/Interpreter and the EMERGENCY/OUT-PATIENT DEPARTMENT ready me in case of a change in diagnosis. If for any reason I am unable to attend follow-up care, return to Emergency Department. I UNDERSTAND THE INSTRUCTIONS I HAVE JUST RECEIVED.

ATTENDING PHYSICIAN SIGNATURE: [redacted]

Date & Time Patient Left Emergency Department: 10:15

[Redacted]

EMERGENCY DEPARTMENT RECORDS

ED CHART COPY

PLUCK
ORIS

FAMILY HEALTH CENTER Room A

Patient Information:

Age: _____ Sex: _____ Race: _____

PMH: None

Allergies _____ _____

Admission Time: **0821** Date: **4/3/97**

Room Time: LMP: **1/1**

Score Time: Pregnant Yes No Dyslex Yes No Tobacco Yes No

Investigations: UTP Urk

Weight: Adult Child Cat

Acuity Level

EMS / Prehospital Triage Record

Time Received: **0802** Received By: **EM JLN** Medic: **0804**

Complaint: **P34**

Vitals: BP _____ Pulse _____ Resp _____ Temp _____

Communication	Education	Ambulation	Pediatric
_____	_____	_____	<input type="checkbox"/> Premature Birth <input type="checkbox"/> Birth Weight _____ <input type="checkbox"/> Language - VML <input type="checkbox"/> Gross Motor - VML <input type="checkbox"/> Fine Motor - VML <input type="checkbox"/> Feeds Bottle Cup <input type="checkbox"/> Other _____

Neurological **Respiratory** **Cardiovascular**

Nausea Tender

Vomiting Constipation

Hemorrhoids Rectal Bleeding

LBM _____

Weight Loss _____ lbs

Abdomen

Flat Soft

Obese Taut

Distended Rigid

Bowel Sounds

RUG _____ LUG _____ RLQ _____ LLQ _____

No Tumor _____ Placement _____

Gastric Content / Swollen

Stool _____ Hemorrhoid

Extremity

RUS _____ LUS _____ RLE _____ LLE _____

Pink Warm Dry

Pale Hot Moist

Flushed Cool Diaphoretic

Cyanosis Cold Poor Turgor

Pulses _____ Edema _____

No Clonus Clonus

Hiccups Frequency

Urgency Discharge

Incontinent Involving Catheter

Clear Foul Odor

Cowy Sediment

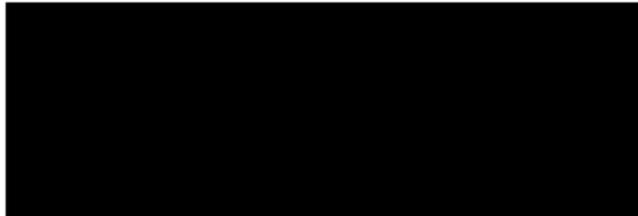
Color _____ Op _____

Birth Control Hysterectomy

Cramping Pain

Vaginal bleeding _____ PostPV

Normal flow _____



NAME: [REDACTED]
PHYS: [REDACTED]
DOB: [REDACTED] AGE: [REDACTED] SEX: [REDACTED]
ACCT: L0200002 LOCATION: ER
STATUS: ER
RADIOLOGY NO: 066152
UNIT NO: M053345
TECHNOLOGIST: JUNE FLOYD RTR

REASON FOR EXAM: T - TRAUMA
OTHER REASON: PT IN MVA. PT IN ER TRA

EXAMS: 000016751 SINUSES-WATER'S VIEW (SINUSW) DATE: 04/03/97

A single water's view of the sinuses were obtained and I do not see any fractures. If further evaluation of the left orbit is warranted, specific films of this area are recommended.

IMPRESSION: SINGLE WATER'S VIEW OF THE SINUSES SHOWS NO EVIDENCE OF A FRACTURE.



CC:

TECHNOLOGIST: JUNE FLOYD RTR
TRANSCRIBED DATE/TIME: 04/03/97 (1058)
TRANSCRIPTIONIST: RAD.SYW
PRINTED DATE/TIME: 04/03/97 (1438) BATCH NO: 3811

NAME: [REDACTED]
PHYS: [REDACTED]
DOB: [REDACTED] AGE: [REDACTED] SEX: [REDACTED]
ACCT: L0200002 LOCATION: ER
STATUS: ER
RADIOLOGY NO: 066152
UNIT NO: M053345
TECHNOLOGIST: JUNE FLOYD RTR

REASON FOR EXAM: [REDACTED]

OTHER REASON: [REDACTED]

EXAMS: [REDACTED]

DATE: 04/03/97

IMPRESSION: [REDACTED]

REPORTED BY: B. ED SHELLEY, M.D.

CC:

TECHNOLOGIST: JUNE FLOYD RTR
TRANSCRIBED DATE/TIME: 04/03/97 (1004)
TRANSCRIPTIONIST: RAD.SYW
PRINTED DATE/TIME: 04/03/97 (1006) BATCH NO: 3805

NAME: [REDACTED]
PHYS: [REDACTED]
DOB: [REDACTED] AGE: [REDACTED] SEX [REDACTED]
ACCT: L0200002 LOCATION: ER
STATUS: ER
RADIOLOGY NO: 066152
UNIT NO: M053345
TECHNOLOGIST: JUNE FLOYD RTR

REASON FOR EXAM: [REDACTED]

EXAMS: [REDACTED]

DATE: 04/03/9

IMPRESSION: [REDACTED]

[Signature]

REPORTED BY: B. ED SHELLEY, M.D.

CC:

TECHNOLOGIST: JUNE FLOYD RTR
TRANSCRIBED DATE/TIME: 04/03/97 (1006)
TRANSCRIPTIONIST: RAD.SYW
PRINTED DATE/TIME: 04/03/97 (1006) BATCH NO: 3805

NAME: [REDACTED]
PHYS: [REDACTED]
DOB: [REDACTED] AGE: [REDACTED] SEX: [REDACTED]
ACCT: L0200002 LOCATION: ER
STATUS: ER
RADIOLOGY NO: 066152
UNIT NO: M053345
TECHNOLOGIST: JUNE FLOYD RTR

[REDACTED]
EXAMS: [REDACTED]

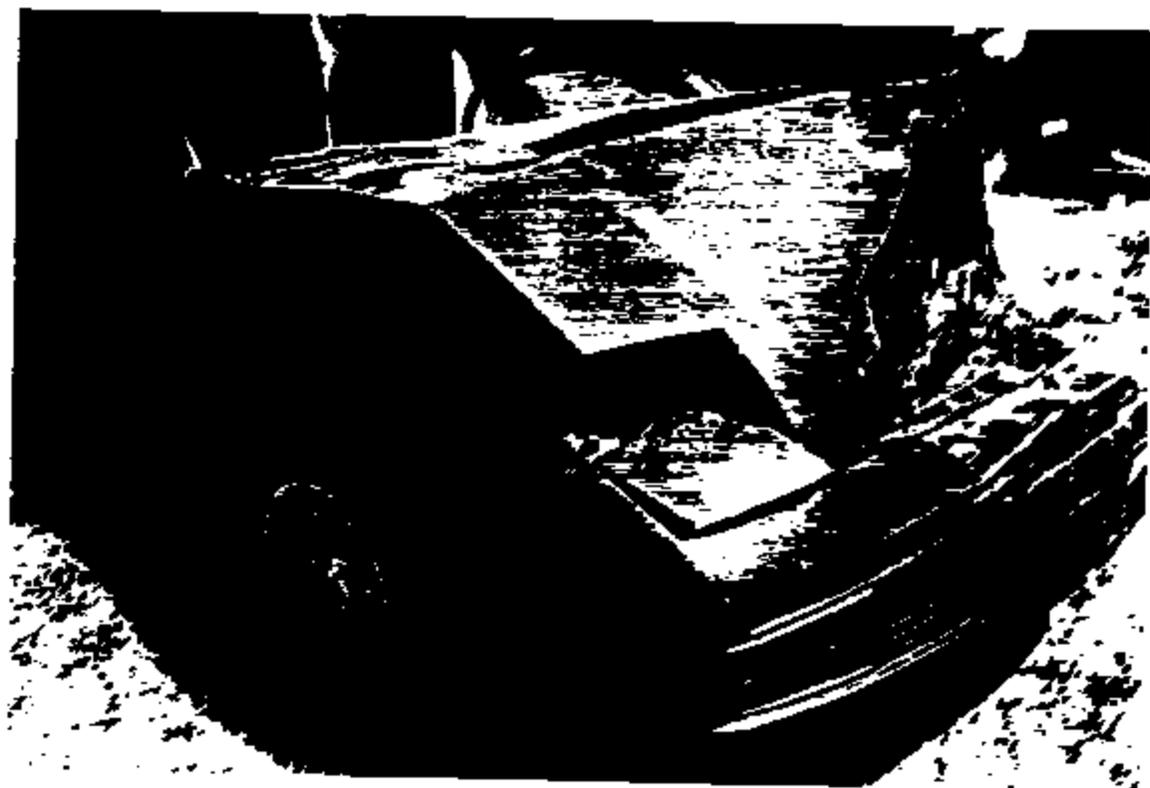
- (CSCTL)

DATE: 04/03/9

REPORTED BY: B. ED SHELLEY, M.D.

CC:

TECHNOLOGIST: JUNE FLOYD RTR
TRANSCRIBED DATE/TIME: 04/03/97 (1005)
TRANSCRIPTIONIST: RAD.SYW
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HARRY PAVLACK & ASSOCIATES, P.A.
ATTORNEYS AT LAW
603 NORTH KINGS HIGHWAY
POST OFFICE BOX 2740
MYRTLE BEACH, SOUTH CAROLINA 29578-2740
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ROBERT S. HAIGHT, JR., P.A., SC, NC
JAMES M. ROBBINS, SC
DEBRA S. HARPE, NC
THOMAS A. McDERMOTT, SC

CYNTHIA M. LOVER, SC
JEFFREY A. KEENAN, SC
NORTON M. GEDDIE, GA, MS
ROBERT G. BACON, SC

FACSIMILE TRANSMITTAL SHEET

Today's Date: 7/23/97
To: TIM KNEEC
From: ROBERT BACON
Number of Pages Including This Transmittal Sheet: 01
Re: [REDACTED]

Mr. Kneec:
The car is located at the owners cousin's house in Conway, SC.
Please meet [REDACTED] at [REDACTED] in Conway at
9 a.m. on Wednesday and he will take you to the car. If you
need further instructions, contact [REDACTED] directly
at [REDACTED].

Call if any questions,
Robert Bacon

IF YOU DO NOT RECEIVE ALL OF THE PAGES INDICATED OR IF THE COPY IS NOT CLEAR PLEASE CALL
(803) 448-9471 OR (800) 868-9471. THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS
ATTORNEY PRIVILEGED AND CONFIDENTIAL INFORMATION INTENDED ONLY FOR THE USE OF THE
INDIVIDUAL OR ENTITY NAMED ABOVE. IF YOU HAVE RECEIVED THIS FACSIMILE IN ERROR PLEASE
NOTIFY THE SENDER AT THE TELEPHONE NUMBER LISTED ABOVE AND RETURN THE COPIES
RECEIVED VIA ORDINARY MAIL.

THANK YOU.



CT System

Service of Process Transmittal Form
Los Angeles, California

08/28/1998

Via Federal Express (2nd Day)

TO: ELAINE NAYSMITH
FORD MOTOR COMPANY-DISCOVERY-OGC
PARKLANE TOWERS WEST STE 800
THREE PARKLANE BLVD
DEARBORN, MI 48128

410394

RE: PROCESS SERVED IN CALIFORNIA

FOR FORD MOTOR COMPANY Domestic State: De

ENCLOSED ARE COPIES OF LEGAL PROCESS RECEIVED BY THE STATUTORY AGENT OF THE ABOVE COMPANY AS FOLLOWS:

- 1. TITLE OF ACTION: [REDACTED] et al vs Ford Motor Company, Inc., et al
- 2. DOCUMENT(S) SERVED: Summons, First Amended Complaint, Notice to Litigants, Attachments, Case Management Conference Questionnaire
- 3. COURT: Superior Court of California, County of Santa Clara
Case Number CV774500
- 4. NATURE OF ACTION: Complaint for alleged negligence resulting in personal injuries.
- 5. ON WHOM PROCESS WAS SERVED: CT Corporation System, Los Angeles, California
- 6. DATE AND HOUR OF SERVICE: By Process server on 08/28/1998 at 10:30
- 7. APPEARANCE OR ANSWER DUE: Within 30 days
- 8. ATTORNEY(S): John C. Stein
408-298-5678
The Boccardo Law Firm LLP
111 West St. John Street
Suite 1100
San Jose, CA 95113

9. REMARKS: Name discrepancy noted.

ELAINE NAYSMITH

08/28/1998

08/28/1998

SIGNED CT Corporation System
PER Jara Keprios /MV
ADDRESS 818 West Seventh Street
Los Angeles, CA 90017
SOP WS 0001977788

Information contained on this transmittal form is recorded for CT Corporation System's record keeping purposes only and to permit quick reference for the recipient. This information does not constitute a legal opinion as to the nature of action, the amount of damages, the answer date, or any information that can be obtained from the documents themselves. The recipient is responsible for interpreting the documents and for taking the appropriate action.

SUMMONS ON FIRST AMENDED COMPLAINT
(CITACION JUDICIAL)

NOTICE TO DEFENDANT: (Aviso a Acusado)
FORD MOTOR COMPANY, INC., STATE OF CALIFORNIA,
a public entity; CALIFORNIA DEPARTMENT OF
TRANSPORTATION (CAL TRANS), a public entity;
RHONDA KAYE WALL and DOES 1-25

AUG 28 1998

YOU ARE BEING SUED BY PLAINTIFF:
(A Ud. le esta demandando)

You have **30 CALENDAR DAYS** after this summons is served on you to file a typewritten response at this court.

A letter or phone call will not protect you; your typewritten response must be in proper legal form if you want the court to hear your case.

If you do not file your response on time, you may lose the case, and your wages, money and property may be taken without further warning from the court.

There are other legal requirements. You may want to call an attorney right away. If you do not know an attorney, you may call an attorney referral service or a legal aid office (listed in the phone book).

Después de que le entreguen esta citación judicial usted tiene un plazo de **30 DIAS CALENDARIOS** para presentar una respuesta escrita a máquina en esta corte.

Una carta o una llamada telefónica no le ofrecerá protección; su respuesta escrita a máquina tiene que cumplir con las formalidades legales apropiadas si usted quiere que la corte escuche su caso.

Si usted no presenta su respuesta a tiempo, puede perder el caso, y le pueden quitar su salario, su dinero y otras cosas de su propiedad sin aviso adicional por parte de la corte.

Existen otros requisitos legales. Puede que usted quiera llamar a un abogado inmediatamente. Si no conoce a un abogado, puede llamar a un servicio de referencia de abogados o a una oficina de ayuda legal (vea el directorio telefónico).

The name and address of the court is: (El nombre y dirección de la corte es)
**SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF SANTA CLARA
191 NORTH FIRST STREET
SAN JOSE, CALIFORNIA 95113**

CASE NUMBER (Número del Caso)
CV774500

The name, address, and telephone number of plaintiff's attorney, or plaintiff without an attorney, is:
(El nombre, la dirección y el número de teléfono del abogado del demandante, o del demandante que no tiene abogado, es)
(408) 298-5678

**JOHN C. STEIN SBN 39417
THE BOCCARDO LAW FIRM LLP
111 WEST ST. JOHN STREET, SUITE 1100
SAN JOSE, CALIFORNIA 95113**

DATE **AUG 19 1998** **Alison V. Lutz** Clerk, by **B. RHODES** Deputy
(Fecha) County Clerk (Actuarial) (Designated)

(SEAL)

NOTICE TO THE PERSON SERVED: You are served

1. as an individual defendant.
2. as the person sued under the fictitious name of (specify):
3. on behalf of (specify): **FORD MOTOR COMPANY, INC.**

- under: CCP 418.50 (corporation) CCP 418.60 (minor)
 CCP 418.20 (defunct corporation) CCP 418.70 (conservatee)
 CCP 418.40 (association or partnership) CCP 418.90 (individual)
 other:

4. by personal delivery on (date):

ATTORNEY OR PARTY WITHOUT ATTORNEY (NAME AND ADDRESS):

PHONE: (408) 298-3678

FOR COURT USE ONLY

JOHN C. STEIN
THE BOCCARDO LAW FIRM LLP
111 WEST ST. JOHN STREET, SUITE 1100
SAN JOSE, CALIFORNIA 95113

(ENCLOSURE)

AUG 7 3 45 PM '93

ATTORNEY FOR (NAME): Plaintiff

INVEST NAME OF COURT, ADDRESS (NUMBER OF COURT HOUSE, IF ANY), AND POST OFFICE BOX NUMBER ADDRESS:

SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF SANTA CLARA
191 NORTH FIRST STREET
SAN JOSE, CALIFORNIA 95113

PLAINTIFF: [REDACTED]

DEFENDANT: (1) FORD MOTOR COMPANY, INC. (2) STATE OF CALIFORNIA, a public entity; CALIFORNIA DEPARTMENT OF TRANSPORTATION (CAL TRANS), a public entity; (3) RHONDA KAYE WALL

DOES 1 TO 25

FIRST AMENDED

COMPLAINT - Personal Injury, Property Damage, Wrongful Death

CASE NUMBER:

CV774500

MOTOR VEHICLE

OTHER (specify): General Negligence

Property Damage

Wrongful Death Products Liability

Personal Injury

Other Damages (specify): Loss of Consortium

1. This pleading, including attachments and exhibits, consists of the following number of pages: 14

2. a. Each plaintiff named above is a competent adult

Except plaintiff (name):

a corporation qualified to do business in California

an unincorporated entity (describe):

a public entity (describe)

a minor

an adult

for whom a guardian or conservator of the estate or a guardian ad litem has been appointed

other (specify):

other (specify):

Except plaintiff (name):

a corporation qualified to do business in California

an unincorporated entity (describe):

a public entity (describe)

a minor

an adult

for whom a guardian or conservator of the estate or a guardian ad litem has been appointed

other (specify):

other (specify):

b. Plaintiff (name):

Is doing business under the fictitious name of (specify):

and has complied with the fictitious business name laws.

c. Information about additional plaintiffs who are not competent adults is shown in Complaint -

Attachment 2c.

(Continued)

COMPLAINT - Personal Injury, Property Damage, Wrongful Death

Page two

3. a. Each defendant named above is a natural person

Except defendant (name): STATE OF CALIFORNIA

- a business organization, form unknown
 a corporation
 an unincorporated entity (describe):

a public entity (describe):

other (specify):

Except defendant (name): CALIFORNIA DEPARTMENT OF TRANSPORTATION

- a business organization, form unknown
 a corporation
 an unincorporated entity (describe):

a public entity (describe):

other (specify):

Except defendant (name): FORD MOTOR COMPANY, INC.

- a business organization, form unknown
 a corporation
 an unincorporated entity (describe):

a public entity (describe):

other (specify):

Except defendant (name):

- a business organization, form unknown
 a corporation
 an unincorporated entity (describe):

a public entity (describe):

other (specify):

b. The true names and capacities of defendants sued as Does are unknown to plaintiff.

c. Information about additional defendants who are not natural persons is contained in Complaint - Attachment 3c.

d. Defendants who are joined pursuant to Code of Civil Procedure section 382 are (names):

4. Plaintiff is required to comply with a claims statute, and

- a. plaintiff has complied with applicable claims statutes, or
 b. plaintiff is excused from complying because (specify):

Claim filed

5. This court is the proper court because

- at least one defendant now resides in its jurisdictional area.
 the principal place of business of a corporation or unincorporated association is in its jurisdictional area.
 injury to person or damage to personal property occurred in its jurisdictional area.
 other (specify):

6. The following paragraphs of this complaint are alleged on information and belief (specify paragraph numbers):

COMPLAINT - Personal Injury, Property Damage, Wrongful Death (Continued)

Page 17/18

7. The damages claimed for wrongful death and the relationships of plaintiff to the deceased are
 listed in Complaint - Attachment ? as follows:

8. Plaintiff has suffered

- | | |
|---|--|
| <input checked="" type="checkbox"/> wage loss | <input type="checkbox"/> loss of use of property |
| <input checked="" type="checkbox"/> hospital and medical expenses | <input checked="" type="checkbox"/> general damage |
| <input type="checkbox"/> property damage | <input checked="" type="checkbox"/> loss of earning capacity |
| <input checked="" type="checkbox"/> other damage (specify): Loss of Consortium | |

9. Relief sought in this complaint is within the jurisdiction of this court.

10. PLAINTIFF PRAYS

For judgment for costs of suit; for such relief as is fair, just, and equitable; and for

- compensatory damages
 (Superior Court) according to proof.
- (Municipal and Justice Court) in the amount of \$
- other (specify): **Prejudgement interest as allowed by law.**

11. The following causes of action are attached and the statements above apply to each: (Each complaint must have one or more causes of action attached.)

- Motor Vehicle
 General Negligence
 Intentional Tort
 Products Liability
 Premises Liability
 Other (specify):

THE BOCCARDO LAW FIRM, LLP

JOHN C. STEIN, ESQ.

(Type or print name)

(Signature of Plaintiff or attorney)

FIRST CAUSE OF ACTION - Motor Vehicle

Page 4

(Number)

ATTACHMENT TO Complaint Cross-Complaint

(Use a separate cause of action form for each cause of action.)

Plaintiff (name):

MV-1. Plaintiff alleges the acts of defendants were negligent; the acts were the legal (proximate) cause of injuries and damages to plaintiff; the acts occurred on (date): 6/6/97

at (place): State Route 85, 400 feet north of MP Bridge No. 37488 and 400 feet North of Great Oaks Blvd. in San Jose, County of Santa Clara, State of California. Defendant and DOES 1-25, inclusive was negligent in control of her vehicle. Defendant made an unsafe lane change in front of plaintiff's vehicle causing plaintiff to strike her vehicle and go out of control and over the side of the steep incline.

MV-2 DEFENDANTS

a. The defendants who operated a motor vehicle are (names): Does 1 to 25b. The defendants who employed the persons who operated a motor vehicle in the course of their employment are (names): Does 1 to 25c. The defendants who owned the motor vehicle which was operated with their permission are (names): Does 1 to 25d. The defendants who entrusted the motor vehicle are (names): Does 1 to 25e. The defendants who were the agents and employees of the other defendants and acted within the scope of the agency were (names): Does 1 to 25f. The defendants who are liable to plaintiff's for other reasons and the reasons for the liability are listed in Attachment MV-2f as follows: Does _____ to _____

SHORT TITLE

CASE NUMBER

STATE OF CALIFORNIA, ET AL.

SECOND CAUSE OF ACTION - General Negligence
(number)

Page 5

ATTACHMENT TO Complaint Cross-Complaint

(Use a separate cause of action form for each cause of action.)

CN-1. Plaintiff (name):

alleges that defendant (name):

Does 1 to 25

was the legal (proximate) cause of damages to plaintiff. By the following acts or omissions to act, defendant negligently caused the damage to plaintiff

on (date): 6/6/97

at (place): State Route 85, 400 feet north of HP Bridge No. 37488 & 400 feet North of Great Oaks Blvd. in San Jose, County of Santa Clara, State of Calif.

(description of reasons for liability):

Defendant [REDACTED], and DOES 1-25, inclusive was negligent in control of her vehicle. Defendant made an unsafe lane change in front of plaintiff's vehicle causing plaintiff to strike her vehicle and go out of control and over the side of the steep incline.

(Please see Page 5-a)

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Defendant FORD MOTOR CO., INC. negligently and carelessly designed, manufactured, assembled, marketed, distributed and sold a 1991 Ford Probe, in that said vehicle when driven, was unsafe with respect to the design and manufacture of the roof system in that it did not withstand the weight of the vehicle when it overturned at the time of the accident.

At the aforementioned time and place, the 1991 Ford Probe, at the moment of impact, seat system failed and plaintiff who was wearing his seatbelt, was not held securely in his seat, causing severe and devastating injuries.

As a direct and proximate result of these defects plaintiff sustained severe injuries which resulted in quadraplegia.

(Required for verified pleading) The items on this page stated on information and belief (specify item numbers, not line numbers):

This page may be used with any Judicial Council form or any other paper filed with this court.

THIRD CAUSE OF ACTION - Premises LiabilityPage 6

(Unsettled)

ATTACHMENT TO Complaint Cross-Complaint

(Use a separate cause of action form for each cause of action.)

Prem.L-1. Plaintiff (name): [REDACTED]

alleges the acts of defendants were the legal (proximate) cause of damages to plaintiff.

On (date): 6/6/97

plaintiff was injured on the following premises in the following

fashion (description of premises and circumstances of injury):

At all times herein mentioned, Defendants, their agents, servants and employees, and each of them, owned, maintained, managed, controlled, inspected, designed, posted, constructed, marked, planned and supervised State Route 85 400 feet north of MP Bridge No. 37488 and 400 feet north of Great Oaks Boulevard, in the City of San Jose, County of Santa Clara, State of California.

On or about June 6, 1997, and for some time prior thereto, the Respondents, their agents, servants and employees, so negligently and carelessly owned, maintained, controlled, designed, laid out, positioned and constructed the said highway, and so negligently and carelessly inspected, (Please see Page 6-a)

Prem.L-2. Count One-Negligence The defendants who negligently owned, maintained, managed and operated the described premises were (names):

 Does _____ to _____

Prem.L-3. Count Two-Withful Failure to Warn (Civil Code section 645) The defendant owners who willfully or maliciously failed to guard or warn against a dangerous condition, use, structure, or activity were (names):

 Does _____ to _____Plaintiff, a recreational user, was an invited guest a paying guest.

Prem.L-4. Count Three-Dangerous Condition of Public Property The defendants who owned public property on which a dangerous condition existed were (names): STATE OF CALIFORNIA, a public entity; CALIFORNIA DEPARTMENT OF TRANSPORTATION (CAL TRANS), a public entity; and

 Does 1 to 25

a. The defendant public entity had actual constructive notice of the existence of the dangerous condition in sufficient time prior to the injury to have corrected it.

b. The condition was created by employees of the defendant public entity.

Prem.L-5. a. Allegations about Other Defendants The defendants who were the agents and employees of the other defendants and acted within the scope of the agency were (names):

 Does 1 to 25

b. The defendants who are liable to plaintiffs for other reasons and the reasons for their liability are described in attachment Prem.L-3.b as follows (names):

1 maintained and repaired the highway and the property immediately
2 adjacent thereto, that the same was in a dangerous, defective and
3 unsafe condition. State Route 85 at the location described above is
4 a straight stretch of freeway elevated approximately 50 feet above
5 Great Oaks Boulevard. The approach to the Great Oaks Boulevard
6 overpass rises up gradually causing a dirt embankment on the side of
7 the road which is extremely steep and drops off approximately 50 feet
8 to the Great Oaks offramp below. During the construction of this
9 highway, the State of California failed to install a guardrail along
10 this steep embankment immediately adjacent to the freeway, which
11 represented a dangerous and defective condition for motorists who
12 were reasonably using the highway and who might foreseeably and
13 inadvertently stray off the traveled portion of the highway onto the
14 shoulder and be subjected to the steep embankment which would cause
15 their vehicle to go out of control and cause serious personal injury.

16 . Further, Defendants, their agents servants and employees, and
17 each of them, had actual or constructive notice of the aforesaid
18 dangerous and defective condition for a reasonable period of time
19 prior to the date of the subject accident to have taken measures to
20 warn or other wise protect users of said roadway against said
21 hazardous and dangerous conditions.

22 Defendants, their agents, servants and employees, and each of
23 them, knew, in the exercise of ordinary care, should have known that
24 the steepness of the embankment and the condition of the roadway at
25 the site of the accident created a reasonably (please see page 6-b)

26 (Required for verified pleading) The items on this page stated on information and belief (specify law numbers, not line
numbers):

27 This page may be used with any Judicial Council form or any other paper filed with this court.

Page 6-3

1 foreseeable risk of injury to users of said roadway, including
2 plaintiff.

3 On or about June 6, 1997, plaintiff, [REDACTED], was
4 lawfully driving a 1993 Ford Probe when the traffic ahead of him
5 stopped suddenly for the Bernal offramp. A vehicle driven by [REDACTED]
6 [REDACTED] changed lanes in front of plaintiff, [REDACTED], suddenly
7 shortening plaintiff's stopping distance and causing him to come into
8 contact with the rear of the Wall vehicle. Upon striking the Wall
9 vehicle, plaintiff attempted to control his vehicle but was
10 unsuccessful and his vehicle was caused to swerve to the right side
11 of the highway and overturn resulting in serious personal injury to
12 the plaintiff. As a direct and proximate result of the aforesaid
13 negligence and carelessness of the defendants and the dangerous
14 condition presented by the lack of guardrail protecting this
15 embankment which condition was dangerous and unsafe causing plaintiff
16 to sustain severe personal injury.

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26 (Required for verified pleading) The items on this page stated on information and belief (specify item numbers, not line numbers):

27 This page may be used with any Judicial Council form or any other paper filed with this court.

Page 5-3

ADDITIONAL PAGE

Attach to Judicial Council Form or Other Court Paper

SHORT TITLE	STATE OF CALIFORNIA, ET AL.	CASE NUMBER:
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FOURTH (number) CAUSE OF ACTION - Products Liability Page 7

ATTACHMENT TO Complaint Cross-Complaint

(Use a separate cause of action form for each cause of action.)

Plaintiff (name): [REDACTED]

Prod.L-1. On or about (date): 6/6/97 plaintiff was injured by the following product:
1991 FORD PROBE, with California License Number

Prod.L-2. Each of the defendants knew the product would be purchased and used without inspection for defects. The product was defective when it left the control of each defendant. The product at the time of injury was being
 used in the manner intended by the defendant.
 used in a manner that was reasonably foreseeable by defendants as involving a substantial danger not readily apparent. Adequate warnings of the danger were not given.

Prod.L-3. Plaintiff was a
 purchaser of the product. user of the product.
 bystander to the use of the product. other (specify):

PLAINTIFF'S INJURY WAS THE LEGAL (PROXIMATE) RESULT OF THE FOLLOWING:

Prod.L-4. Count One-Strict liability of the following defendants who
 a. manufactured or assembled the product (names): FORD MOTOR COMPANY, INC. and

Does 1 to 25

b. designed and manufactured component parts supplied to the manufacturer (names):
FORD MOTOR COMPANY, INC. and

Does 1 to 25

c. sold the product to the public (names):

Does _____ to _____

Prod.L-5. Count Two-Negligence of the following defendants who owed a duty to plaintiff (names):
FORD MOTOR COMPANY, INC.; and

Does 1 to 25

Prod.L-6. Count Three-Breach of warranty by the following defendants (names): FORD MOTOR COMPANY, INC.; and

Does 1 to 25

- a. who breached an implied warranty
- b. who breached an express warranty which was
 written oral

Prod.L-7. The defendants who are liable to plaintiffs for other reasons and the reasons for the liability are
 listed in Attachment-Prod.L-7 as follows:

1 At the above time and place a 1991 Ford Probe, license [REDACTED]
 2 its roof structure and seatbelt system and every component thereof
 3 was defective in that during reasonable and foreseeable use of the
 4 vehicle, plaintiff [REDACTED] was driving his vehicle on
 5 Highway 85 in the County of Santa Clara, State of California, when he
 6 came in contact with the vehicle in front of him and was caused to go
 7 out of control, which resulted ultimately in the vehicle rolling
 8 over.

9 Defendant FORD MOTOR COMPANY, Does 1-25 inclusive, are engaged
 10 in the business of manufacturing, fabricating, designing, assembling,
 11 distributing, constructing, servicing equipping, maintaining,
 12 remanufacturing, advertising, and testing a certain 1991 Ford Probe,
 13 and each and every component thereof. On June 6, 1997 plaintiff was
 14 driving the above-described vehicle on highway 85, in the City of San
 15 Jose, County of Santa Clara, State of California, and while
 16 proceeding South on Highway 85, near the Great Oaks overpass, a
 17 vehicle suddenly changed lanes in front of him, causing him to come
 18 in contact with the rear end of the vehicle, which in turn caused
 19 plaintiff's vehicle to go out of control down an embankment and roll
 20 over. As a result of these actions, which are foreseeable in the
 21 course of operating a vehicle, the roof was not strong enough to
 22 withstand the forces applied to it, and the seatbelt system was not
 23 designed properly to secure the plaintiff in his seat in order to
 24 avoid injury. On the above date and for some time prior thereto,
 25 defendant FORD MOTOR COMPANY, and Does 1-25 were and (See Page L-7a)

26 (Required for verified pleading) The items on this page stated on information and belief (specify item numbers, not line
 27 numbers):

This page may be used with any Judicial Council form or any other paper filed with this court. Page 1-7

1 are engaged in the business of designing, manufacturing, fabricating,
2 assembling, distributing, constructing, servicing equipment, selling,
3 maintaining, advertising, instructing the use of and testing a 1991
4 Ford Probe, License [REDACTED] and each and every component thereof.

5 The design of the roof system and the seatbelt system was so
6 defective in that it allowed plaintiff to sustain severe personal
7 injury when the roof crushed in as a result of the rollover, and the
8 seat system was not adequate to hold plaintiff in position as a
9 result of the rollover.

10 At all times mentioned herein, defendants, and each of them, are
11 strictly liable and are liable by breach of express or implied
12 warranty and are responsible in some manner for the events and
13 happenings herein referred to. In that said vehicle was not fit for
14 ordinary purposes for which the vehicle was used and which caused
15 injury and damage proximately thereby to plaintiff as alleged herein.

16 At all times mentioned herein defendants each of them are
17 strictly liable for the design, manufacture, fabrication,
18 construction, servicing, maintaining and repair, advertising
19 instruction in the use of, tested, failed to test, failed to disclose
20 testing results, failed to recall or correct this vehicle, and failed
21 to advise or otherwise warn either before or after the sale of a
22 certain 1991 Ford Probe, License [REDACTED] and that the same was
23 capable of causing and did in fact cause personal injury to the
24 purchasers and users.

25 At all times mentioned herein for some time prior (See page L-7b)

26 *(Required for verified pleading) The items on this page stated on information and belief (specify item numbers, not line
27 numbers):*

This page may be used with any Judicial Council form or any other paper filed with this court.

Page 1 - 7A

ADDITIONAL PAGE

Attach to Judicial Council Form or Other Court Paper

1 thereto, defendants or agents, employees and servants knew or should
2 have known in the exercise of due care the existence of the defective
3 designs hereinabove mentioned and each and every component part
4 thereof. Defendants, and each of them, negligently and carelessly
5 failed to correct the defective design and negligently and carelessly
6 failed to take reasonable precautions to prevent injuries to persons
7 as a result thereof.

8 Said defendants, their agents, servants, employees, and each of
9 them, knew or should have known in the exercise of ordinary care,
10 that they created a reasonably foreseeable risk of harm to the
11 plaintiff by their defective design which directly and proximately
12 caused the severe paralyzing injuries sustained by plaintiff. As a
13 direct and proximate result of the above-described defective designs,
14 defendants are strictly liable and in addition their negligent and
15 careless action, breach of express or implied warranty, caused
16 plaintiff to sustain severe personal injuries while he was driving
17 the above-described vehicle at the above time and place, rendering
18 him quadriplegic.

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(Required for verified pleading) The items on this page stated on information and belief (specify item numbers, not line numbers):

This page may be used with any Judicial Council form or any other paper filed with this court.

Page 1-7h

1 FIFTH CAUSE OF ACTION - LOSS OF CONSORTIUM

2 Attachment to Complaint

3
4 The allegations set forth in the First Cause of Action herein
5 are incorporated herein as if set forth in full.

6 At all times herein mentioned plaintiff, [REDACTED], was and
7 now is the spouse of plaintiff [REDACTED], who as a legal
8 result of said negligence sustained severe personal injuries, as
9 aforesaid.

10 As a result of the negligence of defendants, and each of them,
11 plaintiff [REDACTED] has incurred loss of consortium, including
12 loss of love, care, comfort, companionship, affection, society,
13 solace, moral and financial support of her husband, [REDACTED]
14 [REDACTED] as a legal result of the said injuries which he sustained.

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26 (Required for verified pleading) The items on this page stated on information and belief (specify item numbers, not line numbers):

27 This page may be used with any Judicial Council form or any other paper filed with this court.

Page 3

ADDITIONAL PAGE

Santa Clara County
Superior Court
Office of the County Clerk-Court Executive Officer

191 North First Street
San Jose, California 95113
(408) 299-2074



CASE NUMBER: CV774500

NOTICE TO LITIGANTS

1. Timely filing and service of pleadings is required per Local Rule 1.1.5.
2. All parties are responsible to be acquainted with the Local Rules of Court and to acquire the proper forms. The rules and forms to be used by the litigants are available for purchase through:

FORMS AND RULES
Rose Printing Co.
20 N. First St., Ste. A
San Jose, CA 95113
(408) 293-8177

RULES
San Jose Post Record
90 N. First St., Ste. 100
San Jose, CA 95113
(408) 287-4866.

3. Notice is given that the Case Management Conference has been scheduled as follows:

DATE: Oct. 27, 1998

TIME: 10:00 AM

DEPT. 16 Turrona

4. You must file and serve a completed Case Management Conference Questionnaire and At-Issue Memorandum at least ten calendar days before the Case Management Conference per Local Rule 1.1.7.
5. Counsel for each party and each self-represented party shall attend and be fully prepared to participate effectively in the Case Management Conference per Local Rule 1.1.6(D).
6. At the Case Management Conference the court will evaluate each case as provided in the CRC 2106 and make appropriate pre-trial orders per Local Rule 1.1.6(D).

SANCTIONS

If you do not file the Case Management Conference Questionnaire and At-Issue Memorandum, attend the Case Management Conference and/or participate effectively in the conference, the court may impose sanctions (including the dismissal of the case and payment of money)

This information is provided by the Santa Clara County Bar Association to assist counsel in fulfilling their professional responsibility to advise their clients, at the outset, of the availability of Alternative Dispute Resolution. You are encouraged to consider whether the client's interest can be better served and the controversy more expeditiously and economically resolved by mediation. Please provide copies to all counsel and clients.

WHAT IS MEDIATION?

Mediation is, in its broadest sense, negotiation carried out with the assistance of a third party. The mediator, in contrast to an arbitrator or a judge, has no power to impose an outcome on dispute parties. Rather, a mediator encourages and facilitates exchanges of information, helps parties understand their own and the other side's interests, and assists in developing options to promote settlement.

HOW DOES MEDIATION DIFFER FROM SETTLEMENT CONFERENCES OR NEUTRAL EVALUATION?

The Bar Association's program distinguishes between mediation and other processes, such as settlement conferences and neutral evaluation. In mediation, a third party does not take sides, refrains from evaluating the case, and leaves control of the outcome with the parties. In settlement conference or neutral evaluation, in contrast, the third party evaluates the strengths and weaknesses of the case, suggests solutions, and often tries to persuade the parties to accept one of the suggested solutions.

Mediation is a voluntary process and should be tailored to the features and needs of each particular case. Mediators have different styles and use different tools and techniques in different settings, so the distinction between mediation and neutral evaluation may not always be clearly evident. Some mediators, for example, are more directive or more likely to challenge each side's view of the case more than others. It is important for parties and their attorneys to understand and be prepared to work within the process and style to be used by the particular third party in their case. Whatever process (such as mediation, neutral evaluation, or a settlement conference) would be best suited for any particular case, and whatever style is to be used (directive or facilitative), it is up to the parties and their attorneys to discuss with the third party and agree upon these features before commencing the process.

WHY MEDIATE?

- Generally, avoid mandatory judicial arbitration (C.C.P. §1141.11)
- Avoid attending initial case management conference
- Opportunity for early resolution
- Entire process is confidential (Evidence Code §1152.5; C.C.P. §703.5)
- Cost and time savings
- Preservation and strengthening of relationships

HOW DOES THE MEDIATION PROCESS GENERALLY WORK?

- The mediator, along with the participants, discuss and agree on the ground rules prior to the mediation. If the parties desire briefs, they should be exchanged at an agreed date prior to the mediation.
- During the mediation session, the mediator meets with the parties and their attorneys in a joint session. The mediator encourages the parties to be the primary participants in the discussions. Because the process is non-adversarial, the attorney's role is primarily one of a counselor and not an advocate.
- Each attorney and/or participant may make a short statement about the dispute, set forth the issues

Continued on other side...

REVISED JANUARY 1, 1996

PROCEDURES FOR FILING FAST TRACK IN SANTA CLARA COUNTY SUPERIOR COURT

THIS PACKET CONTAINS THE FOLLOWING:

- | | |
|--|-------------|
| Rule 1.1 - Differential Civil Case Management | Rev. 1-1-96 |
| Rule 1.2 - Telephonic Appearances at Case Management Conferences | Rev. 1-1-96 |
| Rule 1.3 - Civil Law and Motion and Discovery Proceedings | Rev. 1-1-95 |
| Rule 1.4 - Judicial Arbitration for Civil Cases | Rev. 1-1-95 |
| Form #580 - Case Management Conference Questionnaire and At-Issue Memorandum | Rev. 1-1-95 |
| Form #583 - Request For Telephonic Appearance Case Management Conference | New 1-1-95 |

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(408) 293-8177

RULE 1.1
DIFFERENTIAL
CIVIL CASE MANAGEMENT

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Effective January 1, 1996

RULE 1.1
DIFFERENTIAL
CIVIL CASE MANAGEMENT

1.1.1 PURPOSES

The purposes of the Santa Clara County Superior Court Differential Civil Case Management System effective July 1, 1991 are:

- A. To manage fairly and efficiently, from commencement to disposition, the processing of general civil cases as defined in CRC 2103(b); and
- B. To evaluate each case as provided in CRC 2108 and assign each case to the appropriate case management plan as defined in CRC 2108.

1.1.2 TEAM CONCEPT

Beginning January 1, 1991, civil litigation will be managed primarily by three teams of three judges each sitting in San Jose, and by such judge(s) as the Presiding Judge shall designate to sit in the Palo Alto Branch Court. Each team shall have a team leader designated by the Presiding Judge.

1.1.3 CASES FILED BEFORE JANUARY 1, 1991

Pursuant to CRC 2103(a), any case filed before January 1, 1991 may be included in the Differential Civil Case Management System upon order of the Court and notice to the parties as provided in CRC 1509(c). In general, any new pleading filed may result in such an order and notice. Cases filed before January 1, 1991 on the civil active list will be assigned to a team for all purposes, and shall be subject to all of the civil case management rules set forth below except:

- A. The provisions on filing and service of complaint, cross-complaint, and responsive pleadings shall not apply; and
 - B. For cases filed before January 1, 1991 in which a trial date or status conference has not been set, a Case Management Conference will be scheduled as follows:
 - (1) Upon the filing of an initial ~~at-issue~~ memorandum the Clerk shall give not less than sixty (60) days' notice of the time and place of the Conference. At least ten (10) calendar days before the scheduled Case Management Conference, each party shall file with the Clerk and serve on all other parties a completed Case Management Conference Questionnaire and ~~At-Issue~~ Memorandum.
 - (2) Upon filing of ~~an~~ motion, cross-complaint or complaint in intervention, the Clerk shall give not less than sixty (60) days notice of the time and place of the Conference. At least ten (10) calendar days before the scheduled Case Management Conference, each party shall file with the Court and serve on all other parties a completed Case Management Conference Questionnaire and ~~At-Issue~~ Memorandum.
2. As to cases and all severed issues or causes of action which have been ordered off calendar prior to January 1, 1991, upon the granting of a noticed motion to restore such matter to the civil active list, the Court will set the Conference in no less than sixty (60) days.