THE OSHMAN FIRM, LLC

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AQUEOUS FILM FORMING FOAM (AFFF) INITIAL QUESTIONNAIRE

PLEASE answer every question as completely and thoroughly as possible. Failure to provide complete details will only delay our ability to review and process your case.

PLEASE either print clearly and neatly OR please type form.

PLEASE NOTE, if this questionnaire is being filled out by someone other than the recipient of AFFF exposure, all questions should pertain to the exposed party.

I. PERSONAL/BACKGROUND:

1. Full name: _____
2. Address: _____

   _____
3. Dates at current address: _____
4. Your current occupation:

   _____
5. Have you ever been employed, trained as or volunteered as a firefighter?

   Yes☐ No☐

   If yes, please provide details below:

   _____

   _____
6. Telephone number: Home: ( ) _____ - _____
   Work: ( ) _____ - _____
   Cell: ( ) _____ - _____
7. Email address: _____
8. Date of birth: _____
9. Social Security Number: _____/_____/_____
10. Emergency Contact and phone number other than spouse or partner:

    _____
11. Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

12. If married, name of spouse: _____

13. Date of marriage: _____

14. Spouse's Occupation: _____

15. Spouse's cell phone and e-mail: _____

II. AFFF EXPOSURE DETAILS:

1. Please tell us how were you exposed to aqueous film-forming foams products (AFFF)

_____
_____
_____
_____
_____
_____
_____
_____

2. **Site/Location of Exposure:** List all locations where you claim to have been exposed to AFFF (directly or through ground water):

Site/Location	**Approximate Dates**

III. INJURY INFORMATION:

1. Were you diagnosed with any of the below conditions within 1 year of your exposure to AFFF? (Please check all that apply):

☐ Breast Cancer — Approximate date of diagnosis _____
☐ Kidney Cancer — Approximate date of diagnosis _____
☐ Liver Cancer — Approximate date of diagnosis _____
☐ Pancreatic Cancer — Approximate date of diagnosis _____
☐ Prostate Cancer — Approximate date of diagnosis _____
☐ Testicular Cancer — Approximate date of diagnosis _____
☐ Other (please explain): — Approximate date of diagnosis _____

2. Please provide the name and address for the physicians/hospitals/facilities that diagnosed and treated you for the above listed injury(ies) below, (attach an extra sheet if you need more room):

_____

_____

3. Name & address of the physician or hospital who diagnosed your AFFF-related injury:

DOCTOR/ HOSPITAL NAME	DOCTOR/ HOSPITAL ADDRESS	APPROXIMATE DATES OF TREATMENT	REASON FOR TREATMENT

4. If your loved one died due to AFFF-related complications after exposure to AFFF, please provide their date of death (DD/MM/YYYY):_____

5. Were you or your loved one ever diagnosed with any type of cancer prior to your AFFF exposure? (Please check one) Yes☐ No☐

If YES, please provide the relevant dates and circumstances for this previous diagnosis:

_____
_____
_____
_____

6. Do you currently, or have you ever, smoked or chewed tobacco products?:

   Yes_☐_ No_☐_

7. Why do you believe your exposure to AFFF caused your injuries?

_____

_____

8. Have you hired another attorney to investigate this claim?
   (Please check one) Yes_☐_ No_☐_

   If YES, please describe your last contact with them:

_____

9. Please advise us of any other information you may feel is relevant and/or important to us in evaluating your potential case (attach additional paper as may be necessary):

_____
_____
_____
_____
_____
_____
_____
_____

Please use additional paper if necessary, this information is extremely important!

Dated:_____

Signature:_____