C8 HEALTH PROJECT INDIVIDUAL DATA REQUEST FORM

(For requesting your own data be sent to the C-8 (PFOA) Medical Monitoring Director
for transmission to the Medical Panel AFTER de-identification)

Full Name: _____

If name was different at time of C8 study, please provide that name: _____

Date of Birth: _____ Last 4 digits of Social Security No.: _____

Registration ID: _____

Current Address:

_____

_____

Address at time of participation in C8 Health Project (2005/2006):

_____

_____

Home phone: _____ Email address: _____

By signing this form, I, _____, authorize the release of my C8 Health Project individual data and records by West Virginia University to the C-8 (PFOA) Medical Monitoring Director, Michael K. Rozen (the "Director"), and the Administrator of the Medical Monitoring Program, Garden City Group, LLC (the "Administrator") solely for the purpose of enabling the Medical Panel to determine the continuing length and scope of the Medical Monitoring Program.

I understand that the Director and the Administrator will match my C8 Health Project individual data to my medical data obtained from my medical monitoring in the Medical Monitoring Program. The Administrator will then de-identify my matched data by removing any indication of my identity including my name, address(es), social security number, phone number, email address, and date of birth. The Director and the Administrator will submit this matched de-identified data to the Medical Panel for further analysis to provide recommendations and guidelines for the ongoing length and scope of the Medical Monitoring Program.

I understand that this authorization is voluntary.

I understand that this form does not authorize the Director, the Administrator, or anyone else to disclose this information to any third parties including DuPont or any of its agents or representatives under any circumstances, and that the Director and the Administrator expressly promise and represent that they will not make any disclosures other than the submission of the de-identified data to the Medical Panel.

My consent to release of this information acknowledges that any breach of confidentiality of my personal or medical information shall not be attributable in any way to DuPont or Class Counsel, their agents, representatives or assigns, and I agree to hold those entities harmless should any breach of confidentiality occur.

I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.

I acknowledge that I agree and understand the above.

I certify that the information contained herein is accurate.

Signature: _____ Date: _____