Injury Information

1. Were you or your loved one diagnosed with any of the following? Check all that apply.

☐ Uterine Cancer ☐ Breast Cancer ☐ Infertility ☐ Endometriosis ☐ Endometrial Cancer ☐ None of these

2. On what date was the diagnosis made? _____

3. Was the relaxer used in the five years prior to diagnosis? ☐ Yes ☐ No

4. What age was the injured party when diagnosis was made? _____

5. Age when you first began to use relaxer(s)? _____

6. What brand(s) of relaxer have been used? Please document time frame for each brand.

Common relaxer brands include: Dark & Lovely, Motions, Organic Root Stimulator, Soft & Beautiful, Just for Me, Optimum, Cantu Shea Butter, Affirm, TCB, ORS Olive Oil, Mizani, Isoplus, and Revlon.

Brand #1 _____ From _____ To _____

Brand #2 _____ From _____ To _____

(Use additional pages if needed):

7. How often did/do you use/apply these products?

☐ weekly ☐ monthly ☐ four times per year ☐ less than four times per year ☐ other frequency

8. Did you or the injured person receive hair relaxing treatment in a salon, use the products at home, or both?

☐ Salon ☐ Home ☐ Both

9. If home use, do you have proof of purchase (e.g., receipts and/or used containers) for these products?

☐ Yes ☐ No

10. If relaxer services received in a salon: Do you have salon receipts for these visits? ☐ Yes ☐ No

11. Have there been periods that relaxer use was stopped? If Yes, please state the years/months.

From _____ To _____

From _____ To _____

12. Do you currently use relaxer? ☐ Yes ☐ No

If yes, which brand _____ If no, last date relaxer used? _____ .

13. What pre-existing conditions did/does the injured person have? (e.g., diabetes, previous cancer, obesity,, etc.)

_____

14. When did you first become aware of the link between hair relaxers and your diagnosis?

(Approximate month and year):_____

Physician Information

1. Please provide name and address of primary care physician:

First name: _____ Last name: _____

Facility: _____ Address: _____

City: _____ State: _____ Zip: _____

2. Please provide name and address of diagnosing physician:

First name: _____ Last name: _____

Facility: _____ Address: _____

City: _____ State: _____ Zip: _____

3. Please provide name and address of attending physician for treatment of cancer or infertility:

First name: _____ Last name: _____

Facility: _____ Address: _____

City: _____ State: _____ Zip: _____

Health Insurance Information

Do you have health insurance coverage? ☐ Yes ☐ No

Please provide policy information for all providers throughout span of diagnosis and treatment of cancer or infertility:

Provider Name: _____

Group # _____

Policy # _____

Provider Name _____

Group # _____

Policy # _____

IF YOU HAVE ANY DOCUMENTATION IN YOUR POSSESSION WHICH WILL ASSIST US IN EVALUATING YOUR CASE (MEDICAL RECORDS, PHARMACY RECORDS, PHOTOS, ETC.), PLEASE SEND US A COPY. IF YOU DO NOT HAVE ANY DOCUMENTATION, WE WILL OBTAIN THIS FOR YOU.