Paraquat Litigation Questionnaire

Andrus Wagstaff P.C.

Injured Party's Information:

Name: Daniel Lowrey Maiden Name: N/A

Other Names Used: N/A

Mailing Address: 4597 Linzy Rd

City: Dansville State: New York Zip: 14437

Cell Phone: 585-519-5346 Alternate Number: 5854471120

Email Address: lowreys@juno.com

Date of Birth: 04/12/1957 Social Security Number: 115484903

Do you prefer we send you correspondence by Email or U.S. Mail: Email

Emergency Contact:

Name: ISABELLA LOWREY Relationship: WIFE

Address: 4597 LINZY RD

City: DANSVILLE State: NY Zip: 14437

Phone Number: 5855195346 Alternate Number: 5854471120

Representative's Information (If different from Injured):

Name: N/A Relationship to Injured: N/A

Mailing Address: N/A

City: State: Zip:

Home Phone: n/a Alternate Number:

Email Address: n/a

Representative Information. Please complete this section only if a Minor or a deceased person was exposed to Paraquat and suffered injuries. Otherwise, please skip and proceed to the numbered questions below.

Is the injured person a Minor? No

If yes, are you the Minor's legal guardian _____

If no, who is the Minor's legal guardian? _____

Legal guardian's relationship to Minor: _____

Is the injured person deceased? No

If yes, what is the date of death? _____ Do you have a copy of the Death Certificate? _____

If yes, please keep the original and send us a copy or photograph.

If yes, what is the Cause of Death on the Death Certificate? _____

Are you the deceased person's personal representative? _____

Do you have a copy of the document(s) issued by the Court appointing you as Personal Representative? _____

If yes, please keep the original and send us a copy or photograph.

If you are not the deceased person's personal representative, are you a blood relative? _____

Your relationship to the deceased person: _____

1. Paraquat/Gramoxone Information

Were you or a loved one exposed to Paraquat/Gramoxone? Yes

When were you or a loved one exposed to Paraquat/Gramoxone (month/year)? From 2010 through 2016

Where did you or a loved one live when exposed to Paraquat/Gramoxone?

4597 LINZY RD, DANSVILLE NY 14437

Please describe the duration and intensity of the Paraquat/Gramoxone exposure:

DAILY STRONG ODOR AND DEAD GRASS NEARBY FOR AT LEAST A WEEK AT A TIME

Describe the environment where the Paraquat/Gramoxone exposure occurred:

AIRBORN AS IT WAS SPREAD ON FIELDS AND DITCHES ADJACENT TO MY PROPERTY

Are you a certified pesticide applicator or do you have your restricted use pesticide license? No

If yes, what year did you obtain certification/license? N/A

Do you, or did you, work for a certified pesticide applicator or someone with a restricted use pesticide license? No

If yes, please provide their name and as much contact information as you remember.

N/A

Where did you or your loved one purchase Paraquat/Gramoxone, if known?

Store Name: N/A

Address: N/A

Phone Number: N/A Email Address: N/A

Website: N/A

Can you get proof of your or your loved one's Paraquat/Gramoxone use and/or purchase? No

Do you have receipts? No

If yes, please keep them and send us a copy or photograph of the receipts.

Do you still have the bottle(s)/container(s)? No

If yes, keep them and send us a copy or photograph of the bottle(s)/label(s).

2. Parkinson's Diagnosis Information

Were you or or your loved one was diagnosed with Parkinson's disease? Yes

What was the date you or your loved one was diagnosed with Parkinson's disease? 07/03/2017

What was the date you first learned that you or your loved one's injuries could be related to the exposure to Paraquat/Gramoxone? (month/year) 2018

How did you learn that you or your loved one's injuries could be related to the exposure to Paraquat/Gramoxone?

THOUGH A POSTING ON FACEBOOK

What other chemical exposures did you or your loved one have prior to Parkinson's diagnosis? Please List all that you can think of.

N/A

3. Healthcare Providers

Please list healthcare providers and/or hospitals the injured individual has seen in relation to the Parkinson's diagnosis:

Doctor who diagnosed the Parkinson's disease

Physician Name: DR. JAMES C AZURIN Facility Name: ROCHESTER NEUROLOGICAL ASSOC

Specialty: NEUROLOGY Phone #: 5855463265 Fax #: n/a

Address: 2101 LAC DE VILLE BLVD, STE 1, ROCHESTER, NY 14618

Hospital(s) that have rendered treatment

1. Hospital Name: n/a Phone #: n/a Fax #: n/a

Address: n/a

2. Hospital Name: n/a Phone #: n/a Fax #: n/a

Address: n/a

Treating healthcare providers

1. Physician Name: DR PETER MORRISON Facility Name: UR MEDICINE

Specialty: NEUROLOGY Phone #: 5852763000 Fax #: n/a

Address: 919 WESTFALL RD, STE 100, CLINTON CROSSINGS BLDG C, ROCHESTER, NY 14618

2. Physician Name: _____ Facility Name: _____

Specialty: _____ Phone #: _____ Fax #: _____

Address: _____

3. Physician Name: _____ Facility Name: _____

Specialty: _____ Phone #: _____ Fax #: _____

Address: _____

Pharmacy(ies) that fills and/or has filled prescriptions

1. Pharmacy Name: CVS Phone #: 5853358292 Fax #: n/a

Address: DANSVILLE NY

2. Pharmacy Name: _____ Phone #: _____ Fax #: _____

Address: _____

If you have any medical records, please send in a copy to our office. Please do not send originals.

4. Employment Information

Please provide the following information for the injured person's employers from five years prior to the date of diagnosis to the present.

1. Employer/Job: SELF EMPLOYED BUSINESS OWNER

Address: 4597 LINZY RD, DANSVILLE, NY

Phone #: 5855195346 Fax #: N/A

Job Title: OWNER Job Duties: MANAGER

Dates Employed Start: 01/01/2010 End: 07/01/2019

Reason(s) for leaving: Parkinson's Disease complications

2. Employer/Job: n/a

Address: n/a

Phone #: _____ Fax #: _____

Job Title: _____ Job Duties: _____

Dates Employed Start: _____ End: _____

Reason(s) for leaving: _____

5. Healthcare

Do you have now, or ever had, any of the following types of health insurance?

Medicare: Yes If yes, Medicare HIC # (on ID card): 5UH0EJ0WF00

Date(s) of eligibility (on ID card): 12/01/2020

Medicaid: No If yes, State ID # (on ID card): n/a

Private health insurance: No

1. Name of Insurance Company: n/a

Address (on back of ID card): n/a

Group #: n/a Member ID #: n/a Effective from: _____ to: _____

2. Name of Insurance Company: _____

Address (on back of ID card): _____

Group #: _____ Member ID #: _____ Effective from: _____ to: _____

6. Additional Background Information

Other than Parkinson's disease, what injuries do you or your loved one suffer that you attribute to Paraquat/Gramoxone exposure? Please identify each additional injury and the month/year of the injury onset:

n/a

Has the injured party ever used tobacco products? No If yes, when did you start smoking? n/

Did you quit smoking? _____ If yes, when did you quit smoking? n/a

Were you or your loved one in the Military? No

If so, what branch and what bases: n/a

Have you ever read or been informed by someone about the safety and efficacy of Paraquat/Gramoxone? No

If so, when, what publication/person informed you: n/a

Please provide any additional information you believe is important to your claim:

Signature: Daniel Lowrey Date: 01/20/2021

Signature Certificate

Document Ref.: MAVB2-MWMQ4-RKKXQ-ZXRCK

Document signed by:

Daniel Lowrey

Verified E-mail:
lowreys@juno.com

IP: 24.112.250.118 | Date: 21 Jan 2021 18:44:24 UTC

Daniel Lowrey

Document completed by all parties on:
21 Jan 2021 18:44:24 UTC