Exhibit A

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

IN RE: Stryker Rejuvenate and ABG II Hip Implant Products Liability Litigation	MDL No. 13-2441 (DWF/FLN)
This Document Relates to All Cases:	**MASTER PLAINTIFF'S PRELIMINARY DISCLOSURE FORM**

Instructions: Please provide the following information for each individual plaintiff on whose behalf a claim is being made relating to implantation of the Stryker Rejuvenate and/or Stryker ABG II Hip System. When providing names and addresses please provide the full name and full address, including street number, street name, city, state and zip code. The completed Plaintiff's Preliminary Disclosure Form shall be served on Defense Counsel and Plaintiffs' Liaison Counsel and **SHALL NOT** be filed with the Court.

GENERAL CASE INFORMATION	
SECTION I	
Caption:	Plaintiff's Attorney & Contact Information:
Docket No.:	
Name:	Wrongful Death Claim: ____ Yes ____ No
Address:	Date of Birth:
	Social Security No.:

IMPLANTATION SURGERY INFORMATION			
SECTION II			
Identify Side of Body Where Product at Issue Implanted:		___ Right ___ Left ___ Both check one Fill out the information below for each implant surgery. Add additional sheets as needed.	
Right Side Implantation Surgery		Left Side Implantation Surgery	
Identify Implanted Product at Issue:	___ Rejuvenate ___ ABG II	Identify Implanted Product at Issue:	___ Rejuvenate ___ ABG II
Serial Code/ Catalog No./ Lot No. of Implanted Products (Stem and Neck) at Issue:		Serial Code/ Catalog No./ Lot No. of Implanted Products (Stem and Neck) at Issue:	
Date of Implantation:		Date of Implantation:	
Name and Address of Implanting Surgeon:		Name and Address of Implanting Surgeon:	
Name and Address of Hospital or Clinic where Implant Surgery Performed:		Name and Address of Hospital or Clinic where Implant Surgery Performed:	
ATTACH RECORDS ESTABLISHING PRODUCT IDENTIFICATION AND PAGES WITH MANUFACTURER/PRODUCT STICKERS FOR EACH PRODUCT IMPLANTED			

REVISION SURGERY INFORMATION	
SECTION III - A	
Have you had a Revision Surgery?	_____ Yes _____ No If Yes, fill out information below, if No, skip to Section III-B.
Side of Body?	___ Right ___ Left ___ Both check one Fill out the information below for each implant surgery. Add additional sheets as needed.

Right Side Revision Surgery		Left Side Revision Surgery	
Date of Revision:		Date of Revision:	
Name and Address of Revision Surgeon:		Name and Address of Revision Surgeon:	
Name and Address of Hospital or Clinic Where revision Performed:		Name and Address of Hospital or Clinic Where revision Performed:	
Manufacturers and Sizes of Replacement Device(s):		Manufacturers and Sizes of Replacement Device(s):	
Are you in Possession of Explant:	___ Yes ___ No	Are you in Possession of Explant:	___ Yes ___ No
Location of Explant:		Location of Explant:	
SECTION III – B			
Do You Currently Have a Revision Scheduled?	_____ Yes _____ No If Yes, fill out information below, if No, skip to Section IV.		
Side of Body?	___ Right ___ Left ___ Both check one Fill out the information below for each implant surgery. Add additional sheets as needed.		
Right Side Revision Surgery Scheduled		Left Side Revision Surgery Scheduled	
Date of Scheduled Revision:		Date of Scheduled Revision:	
Name and Address of Scheduled Revision Surgeon:		Name and Address of Scheduled Revision Surgeon:	

Name and Address of Hospital or Clinic Where Revision is Scheduled to be Performed:		Name and Address of Hospital or Clinic Where Revision is Scheduled to be Performed:	
ADDITIONAL MEDICAL INFORMATION			
SECTION IV			
Imaging Study(ing) Conducted? (e.g. MRI, CT, Ultrasound, etc.):	____ Yes ____ No	If Yes, identify where conducted:	
		If Yes, list which reports are available:	
Blood Testing Conducted:	____ Yes ____ No	If Yes, identify where conducted:	
		If Yes, list which reports are available:	
Has your Doctor recommended revision or re-revision surgery but advised that surgery is medically contraindicated and/or would be life threatening?	____ Yes ____ No	If Yes, please provide:	
		Name and Address of Doctor:	
		Date(s) of Discussion:	
		All Individuals Present During Discussion(s):	
		Medical Condition(s) Preventing Surgery:	
		Is Condition Permanent or Temporary?	

Have you had any other hip surgery post-revision (not identified) that you claim is related to the implantation or revision?	____ Yes ____ No	If yes, please provide:	
		Date(s) of Additional Surgery(ies):	
		Name and Address of Surgeon Who Performed:	
		Name and Address of Hospital or Clinic Where Performed:	
		Condition(s) Treated:	
Other than the revision history set forth above, if applicable, and any alleged pain and suffering leading to or associated with the revision(s), are you claiming any other specific residual injury(ies):	____ Yes ____ No	If yes, please describe:	

DATED:	[INSERT SIGNATURE BLOCK FOR COUNSEL]