

DePuy/J&J ASR –Compensation

Application FORM

To,

**The Chairman
Central Expert Committee,
CDSCO, Head Quarter, FDA Bhawan, Kotla Road, New Delhi, 110002
(Submitted directly or through State Level Committee)**

Patient Details

| | | |
|---|-----------|--------------------------|
| Name | | |
| Gender | | |
| Contact Number | | |
| Email ID | | |
| Address | | |
| Address for correspondence | | |
| Date of Birth | | |
| Occupation | | |
| ASR Hip (DePuy/J&J ASR Metal-on-Metal) implanted <i>(please tick the appropriate box)</i> | Left | <input type="checkbox"/> |
| | Right | <input type="checkbox"/> |
| | Bilateral | <input type="checkbox"/> |

First/Initial Surgery Details

| | | |
|---|--|--------------------------|
| Date of First Surgery | | |
| Type of Surgery <i>(please tick the appropriate box)</i> | ASR Hip Resurfacing(DePuy/J&J ASR Metal-on-Metal) | <input type="checkbox"/> |
| | ASR XL Total Hip Replacement(DePuy/J&J ASR Metal-on-Metal) | <input type="checkbox"/> |
| Identification Number of the ASR Hip implanted(DePuy/J&J ASR Metal-on-Metal) | | |
| Hospital Name, address and contact number | | |
| Surgeon Name, address and contact number | | |

***Revision Surgery Details**

| | | |
|---|--|--|
| Date of Revision Surgery | | |
| Hospital Name, address and contact number | | |
| Surgeon Name, address and contact number | | |

*** In case of multiple revision surgeries, provide above details for each such surgery in separate columns.**

Previous medical management Details

| | |
|---|--|
| Has the patient received any medical management by the M/s DePuy International Limited, U.K. (now M/s Johnson & Johnson Pvt. Ltd), if yes, please give the details, If Not received any reimbursement, write No. | |
| Has the patient received any compensation, other than the reimbursement paid for the revision surgery or any other medical management? if yes, please give the details, If Not received, write No. | |
| What are the medical symptoms caused due to use of faulty ASR implant with documentary evidences? | |
| Whether the patient has suffered with any temporary disability or is suffering with any permanent disability, if any, please give details along with the disability certificate issued by a competent authority. | |
| Please attach the recent and relevant clinical test lab report, or any other medical laboratory report (s), or any other document in support of the claim made, if any. | |
| Whether the patient has lost its occupation/job/source of income due to the adverse medical condition which is caused due to faulty ASR implant, if any, please give details. <i>(please enclose a separate sheet having details of loss of wages or income due to such adverse condition, if any. It is advised to attach the evidences in support of such claim)</i> | |
| Discharge slip from the hospital where the patient was implanted ASR (DePuy/Johnson & Johnson Metal-on-Metal Hip Implant) have been operated upon | |

| | |
|--|--|
| Any documentary proof proving the purchase and use of ASR (DePuy/Johnson & Johnson Metal-on-Metal Hip Implant) | |
| Copy of Disability Certificate issued by competent authorities (as guided by Ministry of Social Justice and Empowerment) | |
| Any other relevant information / document (if any) | |

Declaration

I, _____ [*Patient Name*] hereby submit my application to the Chairman, Central Expert Committee for grant of compensation from M/s DePuy International Limited, U.K.(M/s Depuy India), now M/s Johnson & Johnson Pvt. Ltd.

I do hereby declare that the information given in this application form and the documents enclosed herewith are true and correct to the best of my knowledge and belief.

Signed _____

Patient's Name & Signature

Date _____

Address _____

Email and Mobile Number _____

List of Enclosures:

1. Proof of Identity (Document issued by the Government such as Driving Licence, Aadhaar Card, Passport, etc.) (Mandatory)
2. List of documents attached