

**7<sup>TH</sup> AMENDMENT TO DIET DRUG SETTLEMENT  
WITH AMERICAN HOME PRODUCTS CORPORATION**

**Declaration of Prescribing Physician**

Use this form ONLY IF your medical records are unobtainable. This form must be completed and signed by the doctor who prescribed Pondimin® and/or Redux™.

I am the physician who prescribed Pondimin® and/or Redux™ for the following patient:

\_\_\_\_\_  
(Patient's name.)

\_\_\_\_\_  
(Patient's Birth Date.)

\_\_\_\_\_  
(Patient's Social Security Number.)

I prescribed the drug(s) as follows:

Drug Name	Dosage	Approximate Start Date	Approximate End Date

This declaration is an official document sanctioned by the Court before which the Diet Drug Settlement is pending, and submitting it to the Fund Administrator is equivalent to filing it with a court. I declare under penalty of perjury that all of the information provided in this Declaration is true and correct to the best of my knowledge, information and belief.

Date: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

Address of Physician:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_