

UNITED STATES DISTRICT COURT
FOR THE
WESTERN DISTRICT OF NEW YORK

ELIZABETH ANDRES, <i>et al.</i> ,)	
)	
Plaintiffs,)	
)	
v.)	Case No. 1:17-cv-00377-CCR
)	
TOWN OF WHEATFIELD, <i>et al.</i> ,)	
)	
Defendants.)	
-----)	
ALICIA BELLAFIRE, <i>et al.</i> ,)	
)	
Plaintiffs,)	
)	
v.)	Case No. 1:18-cv-00560-CCR
)	
TOWN OF WHEATFIELD, <i>et al.</i> ,)	
)	
Defendants.)	
-----)	
THEODORE WIRTH, III, <i>et al.</i> ,)	
)	
Plaintiffs,)	
)	
v.)	Case No. 1:18-cv-01486-CCR
)	
TOWN OF WHEATFIELD, <i>et al.</i> ,)	
)	
Defendants.)	

CASE MANAGEMENT AFFIDAVIT

I, _____ [Name] _____ of _____ [Address] _____, hereby
certify under oath that:

Personal Injury Claims

1. I have developed the following medical condition(s) which I allege were caused by at least one of the Defendants:

For items 2 – 9, COMPLETE THIS AFFIDAVIT SEPARATELY FOR EACH MEDICAL CONDITION YOU ALLEGE IN THIS LAWSUIT (you may use as many pages as needed to address all your claimed medical conditions)

2. **Alleged Condition #** ____ (name of condition): _____.

a. Symptoms:

_____.

b. Approximate dates I have experienced these symptoms:

_____.

c. Defendant or Defendants that I contend are responsible for this condition:

_____.

3. I have consulted a medical professional regarding this alleged condition.

YES _____ **NO** _____

4. I have received a medical diagnosis or treatment for this alleged condition.

YES _____ **NO** _____

5. I received a medical diagnosis and/or treatment for this alleged condition on the following date(s):

_____.

6. The following medical professional(s) provided my medical diagnosis and/or treatment of this alleged condition:

_____.

7. Contact information of **each** medical professional named in item (6) above [name, address, telephone number]:

_____.

8. I have received an opinion from at least one medical professional regarding the cause of this alleged condition:

YES _____ NO _____

9. If you answered “YES” to number 8, please provide the following information:

a. I have received a written medical causation opinion.

YES _____ NO _____

b. I have received a verbal medical causation opinion.

YES _____ NO _____

c. Other (please explain):

_____.

d. Contact information of **each** medical professional that provided a causation opinion [name, address, telephone number]:

_____.

10. For purposes of this lawsuit, I agree to release my medical records regarding my alleged condition(s) and have signed a release furnished by my legal counsel which I include with this Case Management Affidavit.

Property Damage Claims

11. I am making a claim for property damages related to contamination migrating from the Landfill.

YES _____ **NO** _____

If you answered "YES", proceed to questions 12-14.

If you answered "NO", proceed to the signature section.

12. What is the address of the property(ies) for which you are claiming damages?

Property 1: _____.

Property 2: _____.

13. Are you the current owner of the listed property(ies)?

Property 1:

YES _____ **NO** _____

Property 2:

YES _____ **NO** _____

14. What are the years of ownership for the listed property(ies)?

Property 1: _____.

Property 2: _____.

I hereby certify under oath that the foregoing information is true, accurate, and complete to the best of my knowledge.

Signature of Plaintiff

Date

Printed Name of Plaintiff

Printed Name of Parent/Guardian, if Plaintiff is a Minor

Printed Name of Fiduciary, if Plaintiff is Deceased

Case in which Plaintiff is a claimant [please check only one]:

- *Andres v. Town of Wheatfield* []
- *Bellafaire v. Town of Wheatfield* []
- *Wirth v. Town of Wheatfield* []