

## Statutory Declaration Victoria

*Insert the name, address and occupation (or alternatively, unemployed or retired or child) of person making the statutory declaration.*

I, ....., [occupation]

of, .....

in the State of Victoria, make the following statutory declaration under the **Oaths and Affirmations Act 2018**.

*Set out matter declared to in numbered paragraphs. Add numbers as necessary.*

I solemnly and sincerely declare and affirm that:

1. I **have / have not\*** entered into a deed of release with the defendants or any one of them, in the Supreme Court proceedings 2017/279308 or any of their related entities in respect of a claim for damages for breast augmentation surgery performed at any of the TCI premises located at Gold Coast, Bondi Junction or Parramatta (**TCI BAS**). [*\*Strike out whichever does not apply to you.*]
2. I **have / have not\*** already received an amount of compensation in full and final satisfaction of a claim for damages in connection with my TCI BAS.

### Update about my injuries, disabilities and treatment

3. I **have / have not\*** suffered INJURIES AND COMPLICATIONS as a result of undergoing TCI BAS. My injuries are set out in **Exhibit A**. [*Complete **Exhibit "A"**: Injuries and complications.*]
4. An up-to-date summary of my injuries and disabilities, is as follows:

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### Past treatment

5. I **have / have not\*** undergone REVISION SURGERIES or PROCEDURES in the past to address injuries sustained as a result of my TCI BAS. [*Explain.*]

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### Future treatment

6. I **do / do not\*** require REVISION SURGERY or OTHER TREATMENT in the future because of injuries sustained as a result of my TCI BAS. [*Explain.*]

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**Medication and other treatment**

7. I **have / have not\*** required MEDICATION in the past, to treat my injuries and disabilities (including any psychiatric injuries) suffered as a result of my TCI BAS, not including any pain medication required during the standard two week post operative period. [*Explain, including time periods medication required, and whether currently still being taken.*]

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8. I **have / have not\*** undergone other NON-SURGICAL TREATMENT in the past, in respect of my injuries and disabilities suffered as a result of my TCI BAS [*such as chemotherapy, consultations with a pain management specialist, physiotherapy, psychological treatment etc.*].

[*Explain. For example, if you have seen your GP or specialist about pain, disfigurement, rupture, seroma, contracture, ALCL, or any other physical injury or complication you have experienced, set out the treatment here, including the name, specialisation and address of the doctors you had treatment with.*]

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.....  
.....

9. I **am / am not\*** STILL BEING TREATED / REQUIRE REGULAR MEDICATION in respect of my injuries and disabilities (including any psychiatric injuries) suffered as a result of my TCI BAS. [*If yes, complete: **Exhibit "B"**. Types of treatment includes chemotherapy, consultations with a pain management specialist, physiotherapy, psychological treatment, pain medication, etc.*]

**Disabilities or functional effects**

10. I **have / have not\*** suffered DISABILITIES OR FUNCTIONAL EFFECTS, as a result of the injuries I suffered from my TCI BAS, not including the normal two-week post-operative rehabilitation period. [*Explain the ways your ability to function on a day-to-day basis and perform your activities of daily life has been affected, including your ability to lead a normal life, if relevant.*] [*If yes, complete: **Exhibit "C"**: Activities of Daily Living.*]

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### Effects to my life

11. The effects of the TCI BAS on my life, and the difference between my pre-TCI BAS life and circumstances, and my post-BAS life and circumstances, is summarised as follows (cl 10.3, schedule 1, scheme) *[please give brief details regarding the impact of the TCI BAS on you enjoyment of life, your income, your capacity to work and your capacity to care for yourself and others, including details of your job title and work (if your injuries have affected your work)]*:

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12. Medicare. [*\*Select whichever applies to you.\**] ✓

|           |  |                          |
|-----------|--|--------------------------|
| (a)       | I <b>HAVE</b> used Medicare to pay for expenses to treat injuries related to my TCI BAS, such as imaging fees, specialist fees, or revision surgery fees.<br><br><i>I understand that I may need to repay Medicare the amounts paid by Medicare to treat my TCI BAS injuries, if I become entitled to receive compensation over \$5,000 in respect of my injuries.</i> | <input type="checkbox"/> |
| <b>OR</b> |  |                          |
| (b)       | I <b>HAVE NOT</b> used Medicare to pay for expenses to treat injuries related to my TCI BAS.<br><br><i>I understand I may not incur any repayment obligation to Medicare.</i>  | <input type="checkbox"/> |

13. NDIS or other Government funding or supports received in connection with my TCI BAS. ✓

|     |   |  |
|-----|---|--|
| (a) | <p><b>I HAVE</b> received treatment benefits, funding or support in connection with the injuries sustained from my TCI BAS, from:</p> <ul style="list-style-type: none"> <li>• National Disability Insurance Scheme (NDIS).</li> <li>• Other State or Commonwealth Government organisation [<i>list</i>]:</li> </ul> <p>.....</p> <p><i>I understand that I may have obligations to repay NDIS or other State or Commonwealth Government body for funding I may have received towards my TCI BAS treatment expenses, if I receive a compensation amount for injuries.</i></p> <p style="text-align: center; font-size: 1.2em; font-weight: bold; color: blue;">OR</p> | <input type="checkbox"/><br><br><input type="checkbox"/> |
| (b) | <p><b>I HAVE NOT</b> received any NDIS, State or Commonwealth benefits, funding or support in connection with my TCI BAS injuries.</p>  | <input type="checkbox"/>                                 |

14. Private health insurance. [*Select whichever applies to you.*] ✓

|     |  |                          |
|-----|--|--------------------------|
| (a) | <p><b>I AM CURRENTLY, OR HAVE BEEN AT ANY TIME FROM THE DATE OF MY TCI BAS, TO PRESENT,</b> a member of a private health insurance fund for private health coverage:</p> <p>Name of private health fund: .....</p> <p>Member number: .....</p> <p style="text-align: center; font-size: 1.2em; font-weight: bold; color: blue;">If yes:</p>  | <input type="checkbox"/> |
| (b) | <p><b>I HAVE / HAVE NOT*</b> received any benefits or funding, for any treatment in connection with my TCI BAS injuries, from my private health insurer. [<i>Strike out whichever does not apply.</i>]</p> <p><i>I may have contractual obligations to repay my private health fund, for benefits I received towards my treatment expenses for TCI BAS injuries, if I receive a compensation amount for my injuries.</i></p> <p style="text-align: center; font-size: 1.2em; font-weight: bold; color: blue;">OR</p> | <input type="checkbox"/> |
| (c) | <p><b>I HAVE NOT HAD PRIVATE HEALTH INSURANCE COVERAGE, AT ANY TIME FROM THE DATE OF MY TCI BAS, TO PRESENT.</b></p>   | <input type="checkbox"/> |

- 15. I understand that the updated information provided in this statutory declaration and the attached annexures, supersedes the information that I have previously provided Turner Freeman Lawyers including by way of my (registration) questionnaire.
- 16. I understand that I have an obligation to act honestly and the information I have given in this statutory declaration including the information I have given at Annexures A, B and C, is true and correct.

**I declare that the contents of this statutory declaration are true and correct and I make it knowing that making a statutory declaration that I know to be untrue is an offence.**

*Signature of person making the declaration* x \_\_\_\_\_

*Place (City, town or suburb)* **Declared at** \_\_\_\_\_ **\*in the state of Victoria**

*Date* on \_\_\_\_\_

*Signature of authorised statutory declaration witness* **I am an authorised statutory declaration witness and I sign this document in the presence of the person making the declaration:**

*Date* x \_\_\_\_\_

on \_\_\_\_\_

*Name, capacity in which authorised person has authority to witness statutory declaration, and address (writing, typing or stamp)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A person authorised under section 30(2) of the **Oaths and Affirmations Act 2018** Vic to witness the signing of a statutory declaration.

## CERTIFICATE IDENTIFYING EXHIBIT

Exhibit A

This is the exhibit marked "A" now produced and shown to me,  
registered group member: .....,  
at the time of making my declaration on date: .....

Signed: .....

*[registered group member]*

Witnessed by: .....

*[Address and capacity of authorised witness]* JP Stamp

Exhibit "A":  
Injuries and disabilities

## "A"

### Injuries and complications suffered as a result of undergoing my TCI BAS

**Instructions**

- Provide details of any physical or psychological injuries you have suffered, below.
- Being unhappy with the staff or service provided to you by TCI such as being rushed out after the surgery, is not a "complication" or "injury".
- Pain, discomfort, swelling or other issues normally experienced in the two-week post-operative recovery period, are not "complications" or "injuries".

**CURRENT SEVERITY OF SYMPTOMS**

If you were to spend the rest of your life with your symptoms just the way they are now, how would you feel about that?

0            1            2            3            4            5            6            7            8            9            10

Pleased

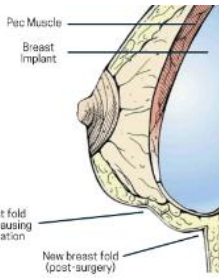
Indifferent

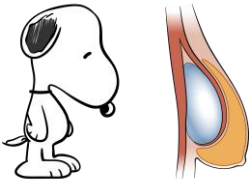
Terrible

| Injuries / complications. | Reference guide / general explanation of complications           | Suffered as a result my initial TCI BAS.<br><br>Yes/No  | Details, and whether injury is still suffered.   |
|---------------------------|--|---|--|
| None.                     | I have not suffered any injuries or disabilities.                | <input type="checkbox"/><br><br><i>Only tick if you have not suffered any injuries as a result of your TCI BAS.</i> | <i>Not applicable.</i>   |
| Pain.                     | For example, breast, back, neck, chest, arm/s, generalised pain. | Yes <input type="checkbox"/><br>No <input type="checkbox"/>   | Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br><br>Brief details:<br>.....<br>.....<br>.....<br><br>Location of pain:<br>.....<br><br>How often do you experience pain on a weekly basis:<br><br>Every day: <input type="checkbox"/> Some days: <input type="checkbox"/> Occasionally: <input type="checkbox"/><br>Other:<br><input type="checkbox"/> ..... |

|                      |   |   |  |
|----------------------|---|---|--|
|                      |   |   | Pain Rating: Rate pain at its worst, in the last week out of 10, 10 being highest severity:<br>...../ 10   |
| Discomfort.          | General discomfort.   | Yes <input type="checkbox"/><br>No <input type="checkbox"/> | Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/><br>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br>Brief details:<br>.....<br>.....<br>.....<br>Discomfort Rating: Rate discomfort at its worst, in the last week out of 10, 10 being highest severity:<br>...../ 10  |
| Psychiatric effects. | Effects to mental health such as anxiety, distress, stress, PTSD, depression. | Yes <input type="checkbox"/><br>No <input type="checkbox"/> | Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br>Brief details:<br>.....<br>.....<br>.....<br>If you are suffering with a psychiatric/psychological condition, had you ever suffered these symptoms before you had breast implants? If yes, for what period of time?<br>.....<br>.....<br>.....<br>If you had previously suffered with a psychological/psychiatric condition, had you ever required treatment before the implants? If so, what treatment did you have? (eg. seeing your GP, psychologist, psychiatrist, and/or being prescribed medication) and for how long?<br>.....<br>.....<br>.....<br>If you had previously suffered with a psychological/psychiatric condition, for which you have required treatment before you had |



|   |  |   |   |
|---|--|---|---|
|   |  |   | breast implants, provide the names, speciality and addresses of the doctor/s you had treatment with:<br>.....<br>.....<br>.....   |
| Poor aesthetic outcome.                                     | Unsatisfactory appearance of breasts post-surgery and/or did not result in your desired outcome.   | Yes <input type="checkbox"/><br>No <input type="checkbox"/> | Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br>Brief details. If you are unhappy about your aesthetic outcome, explain what it is you are unhappy about:<br>.....<br>.....<br>.....                          |
| Mal-positioning.  | Implants placed too high, too low, too far laterally (to the side), uneven placement.<br>May cause double bubble deformity, if positioned too low, or the implant drops below the inframammary fold, or waterfall deformity if sitting too high. | Yes <input type="checkbox"/><br>No <input type="checkbox"/> | Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/><br>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br>Brief details:<br>.....<br>.....<br>.....                                     |
| Double Bubble.  | Distinct bulges, or bubbles, are visible in the breast, typically one over the other. May occur, for example, if the implant is positioned too low.  | Yes <input type="checkbox"/><br>No <input type="checkbox"/> | Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/><br>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br>Brief details:<br>.....<br>.....<br>.....<br>.....<br>.....<br>.....<br>..... |
|   |   |   |   |
| Waterfall deformity (snoopy nose, or snoopy dog deformity). | Sagging appearance where the breast tissue seems to fall downwards and flow down over the implant, including with a  | Yes <input type="checkbox"/><br>No <input type="checkbox"/> | Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/><br>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br>Brief details:  |

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|                     | <p>downward facing or low nipple.</p>  <p>May be due to implant placement too high, unaddressed pre-existing ptosis (sagging), performing a breast augmentation alone without a breast lift (mastopexy) if indicated.</p> <p>May also be an inherent long-term complication of breast augmentation surgery.</p> |  | <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>   |
| <p>Rupture.</p>     | <p>Intracapsular rupture: where the implant ruptures and the fluid stays within the fibrous 'capsule' formed by the body around the implant. May eventually progress into an extracapsular rupture.</p> <p>Extracapsular rupture: where the implant fluid leaks through the fibrous capsule the body has formed around the implant, spreading into the breast tissue and surrounding muscle.</p> | <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> | <p>Left implant: <input type="checkbox"/> Right implant: <input type="checkbox"/></p> <p>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Brief details:</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> |
| <p>Haemorrhage.</p> | <p>Excessive bleeding during or after the surgery.</p>   | <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> | <p>Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/></p> <p>Brief details:</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>  |
| <p>Haematoma.</p>   | <p>Internal collection of blood beneath the skin.</p> <p>Can make one breast appear larger than the other and create a bruise</p>  | <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> | <p>Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/></p> <p>Details:</p> <p>.....</p>   |

|                     |   |  |  |
|---------------------|---|--|--|
|                     | <p>on the surface and be painful.</p> <p>Haematoma may place you at higher risk of suffering capsular contracture.</p>  |  | <p>.....</p> <p>.....</p>  |
| Seroma.             | <p>Accumulation of clear fluid in the breast. May need to be drained.</p>   | <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>   | <p>Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/></p> <p>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Brief details:</p> <p>.....</p> <p>.....</p> <p>.....</p> |
| Infection.          | <p>Infection at the incision site, or inside the body, around the implant.</p> <p>Can complicate wound healing, cause pain and affect scarring.</p>   | <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>   | <p>Location of infection:</p> <p>.....</p> <p>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Brief details:</p> <p>.....</p> <p>.....</p> <p>.....</p>  |
| Excessive scarring. | <p>Thickened or hardened scars, excessively long or wide scars, unsightly or uneven stars etc.</p> <p>Can be exacerbated by poor incision/technique, requirement for multiple revision surgeries, infection, etc.</p> | <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>Do not include normal scarring as may be expected from undergoing the initial TCI BAS.</p> | <p>Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/></p> <p>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Brief details:</p> <p>.....</p> <p>.....</p> <p>.....</p> |
| Wound dehiscence.   | <p>Partial or total breakdown of wound, failure of the wound to close properly.</p>   | <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>   | <p>Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/></p> <p>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Brief details:</p> <p>.....</p> <p>.....</p> <p>.....</p> |

|  |   |  |  |
|--|---|--|--|
| <p>Capsular contracture.</p>   | <p>The body naturally forms a "capsule" of scar tissue around the implants.</p> <p>Sometimes the capsule can become unusually hardened and contract around the implant. This is called capsular contracture.</p> <p>This can cause pain and also lead to other issues such as distorted looking, tight, mishappen breasts, poor aesthetic outcome, variations in size and shape (asymmetry), deformity and shifts in the position of the implant.</p> | <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> | <p>Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/></p> <p>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Brief details:</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> |
| <p>Breast hardness.</p>  | <p>Unusual firmness of the breast.</p> <p>Can be a sign of capsular contracture.</p>  | <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> | <p>Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/></p> <p>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Brief details:</p> <p>.....</p> <p>.....</p> <p>.....</p>   |
| <p>Local anaesthetic toxicity and/or complications such as:</p> <ul style="list-style-type: none"> <li>• cardiac arrest;</li> <li>• seizures.</li> </ul> | <p>May occur when too much anaesthesia is given.</p>  | <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> | <p>Still suffered?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Brief details:</p> <p>.....</p> <p>.....</p> <p>.....</p>  |
| <p>Pneumothorax.</p>   | <p>Air trapped between the lung and chest wall.</p>   | <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> | <p>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Brief details:</p> <p>.....</p> <p>.....</p> <p>.....</p>   |
| <p>Breast implant illness (BII).</p>   | <p>May be a wide range of symptoms such as: joint and muscle pain, hair loss, chronic fatigue,</p>  | <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> | <p>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Brief details:</p>  |

|                               |  |   |   |
|-------------------------------|--|---|---|
|                               | memory loss, rashes, gastrointestinal problems, headaches, anxiety, depression and concentration problems.   |   | .....<br>.....<br>.....   |
| Inadequate pocket dissection. | The excavation of tissue and muscle to create the pocket where the implants are placed, is inadequate. The pocket may be too big, too small, or mal-positioned.<br><br>May result in implant animation (implant moves around if pocket too large), implant relocating laterally to the side, implant sitting too high, too low or asymmetrically (unevenly). | Yes <input type="checkbox"/><br><br>No <input type="checkbox"/> | Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/><br><br>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br><br>Brief details:<br>.....<br>.....<br>.....<br>.....<br>..... |
| Swelling / fluid build-up.    | Accumulation of fluid in the breast area post-surgery or on a long-term basis.   | Yes <input type="checkbox"/><br><br>No <input type="checkbox"/> | Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/><br><br>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br><br>Brief details:<br>.....<br>.....<br>.....                   |
| Asymmetry.                    | Uneven size, shape and/or position of implants.<br><br>Can be related to implant malposition or capsular contracture, for example.   | Yes <input type="checkbox"/><br><br>No <input type="checkbox"/> | Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/><br><br>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br><br>Brief details:<br>.....<br>.....<br>.....                   |
| Nerve damage.                 | Surgical error or poor technique may result in damage to nerves.<br><br>Can cause pain and numbness.   | Yes <input type="checkbox"/><br><br>No <input type="checkbox"/> | Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/><br><br>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br><br>Brief details:<br>.....<br>.....<br>.....                   |

|                                       |   |   |   |
|---------------------------------------|---|---|---|
| Numbness.                             | Loss of sensation.  | Yes <input type="checkbox"/><br><br>No <input type="checkbox"/> | Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/><br><br>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br><br>Brief details:<br>.....<br>.....<br>..... |
| Headaches.                            | Self-explanatory.   | Yes <input type="checkbox"/><br><br>No <input type="checkbox"/> | Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br><br>Brief details:<br>.....<br>.....<br>.....   |
| Sensitive nipples (or hyperesthesia). | Increased sensitivity or discomfort in the nipple area.   | Yes <input type="checkbox"/><br><br>No <input type="checkbox"/> | Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/><br><br>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br><br>Brief details:<br>.....<br>.....<br>..... |
| Rippling.                             | Visible folds or waves on the skin, from the implant.   | Yes <input type="checkbox"/><br><br>No <input type="checkbox"/> | Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/><br><br>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br><br>Brief details:<br>.....<br>.....<br>..... |
| Symmastia.                            | The breasts touch or sit too close together at the centre of the chest, sometimes called 'uni-boob'.<br><br>Can be caused by implant displacement, inadequate pocket dissection, incorrect placement. | Yes <input type="checkbox"/><br><br>No <input type="checkbox"/> | Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br><br>Brief details:<br>.....<br>.....<br>.....   |

|   |  |   |   |
|---|--|---|---|
| Breast implant associated anaplastic large-cell lymphoma ( <b>ALCL</b> ). | A rare type of cancer associated with textured implants.<br><br>Allergan textured implants had a higher risk of developing BIA-ALCL than others on the market. | Yes <input type="checkbox"/><br><br>No <input type="checkbox"/><br><br>Only tick "Yes", if you have been diagnosed with this condition by a doctor. | Left breast: <input type="checkbox"/> Right breast: <input type="checkbox"/><br><br>Still suffered? Yes <input type="checkbox"/> No <input type="checkbox"/><br><br>Brief details:<br>.....<br>.....<br>..... |
|---|--|---|---|

I understand that I have an obligation to act honestly and am satisfied that the information I have given in this statutory declaration including this **Exhibit A**, is true and correct (clause 11.2 of the Settlement Distribution Scheme).

Signature: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Date: \_\_\_\_\_

## CERTIFICATE IDENTIFYING EXHIBIT

### Exhibit B

This is the exhibit marked "B" now produced and shown to me,  
registered group member: .....,  
at the time of making my declaration on date: .....

Signed: .....

*[registered group member]*

Witnessed by: .....

*[Address and capacity of authorised witness]* JP Stamp

Exhibit "B":  
Ongoing treatment and  
medication



## "B"

### My ongoing treatment and medication (if any)

#### Instructions

➤ Provide details of any ongoing treatment including medication, below.

A general description about my ongoing treatment, follows:

.....  
.....  
.....

#### ONGOING TREATMENT

##### Pain Medication

|   |   |
|---|---|
| <p>Are you <b>currently</b> taking any pain medication as a result of your breast augmentation surgery with TCI?</p> <p>If so, for how many years or months have you been taking the medication?</p> <p>.....</p> <p>What medication do you take? What dosage do you take?</p> <p>.....<br/>.....<br/>.....</p>                   | <p><input type="checkbox"/> Yes<br/><input type="checkbox"/> No</p> |
| <p>Did you have a pre-existing condition that required you to take pain medication prior to your breast augmentation surgery with TCI?</p> <p>If yes, what medication did you take and what dosage?</p> <p>.....</p> <p>If yes, please provide the name and address of the doctor who prescribed the medication.</p> <p>.....</p> | <p><input type="checkbox"/> Yes<br/><input type="checkbox"/> No</p> |

**Other Medications**

|   |   |
|---|---|
| Are you <b>currently</b> taking any medication to treat a psychological condition, infection or other complication you have suffered as a result of your breast augmentation surgery with TCI?<br>If so, for how many years or months have you been taking medication?<br>.....<br>What medication do you take? What dosage do you take?<br>.....<br>Who prescribed the medication? Please provide the name & address of the doctor/s who prescribed it.<br>..... | <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No |
| Did you have a pre-existing condition that required you to take this other medication prior to your breast augmentation surgery with TCI?<br>If yes, what medication did you take, and what dosage?<br>.....<br>If yes, please provide the name and address of the doctor who prescribed the medication.<br>.....   | <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No |

**Other Treatment**

|   |   |
|---|---|
| Do you <b>currently</b> receive any other type of treatment as a result of your breast augmentation surgery with TCI. For example, chemotherapy, consultations with a pain management specialist, physiotherapy, psychological treatment etc?<br>If yes, what type of treatment?<br>.....<br>.....<br>.....<br>How frequently do you receive this treatment?<br>.....<br>Who provides this treatment? Please provide the name and address of the doctor/s who provides it.<br>..... | <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No |
|---|---|

I understand that I have an obligation to act honestly and am satisfied that the information I have given in this statutory declaration including this **Exhibit B**, is true and correct (clause 11.2 of the Settlement Distribution Scheme).

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

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

## CERTIFICATE IDENTIFYING EXHIBIT

Exhibit C

This is the exhibit marked "C" now produced and shown to me,  
registered group member: .....,  
at the time of making my declaration on date: .....

Signed: .....

*[registered group member]*

Witnessed by: .....

*[Address and capacity of authorised witness]* JP Stamp

Exhibit "C":  
Activities of daily living

"C"

Activities of daily living

Instructions

- Some women find that complications from breast augmentation surgery, affect their activities of daily living.
- For each question, check the response that best describes how much your activities have been affected by the complications you have suffered. Please tick the box that best describes the impact of the complications over the last three months. Please make sure you mark an answer in all three columns for each question.

| How do symptoms or conditions affect your: |   |   |
|--|---|---|
| (a)  | Ability to do household chores (cooking, laundry, house cleaning)?  | <input type="checkbox"/> Not at all<br><input type="checkbox"/> Somewhat<br><input type="checkbox"/> Moderately<br><input type="checkbox"/> Quite a bit |
| (b)  | Ability to do physical activities such as sports, hobbies, recreational activities, walking, swimming, or other exercise? | <input type="checkbox"/> Not at all<br><input type="checkbox"/> Somewhat<br><input type="checkbox"/> Moderately<br><input type="checkbox"/> Quite a bit |
| (c)  | Ability to travel by car or bus for a distance greater than 30 minutes away from home?                                    | <input type="checkbox"/> Not at all<br><input type="checkbox"/> Somewhat<br><input type="checkbox"/> Moderately<br><input type="checkbox"/> Quite a bit |
| (d)  | Participating in social activities outside your home?   | <input type="checkbox"/> Not at all<br><input type="checkbox"/> Somewhat<br><input type="checkbox"/> Moderately<br><input type="checkbox"/> Quite a bit |
| (e)  | Emotional health (nervousness, depression, etc.)?   | <input type="checkbox"/> Not at all<br><input type="checkbox"/> Somewhat<br><input type="checkbox"/> Moderately<br><input type="checkbox"/> Quite a bit |

I understand that I have an obligation to act honestly and am satisfied that the information I have given in this statutory declaration including this **Exhibit C**, is true and correct (clause 11.2 of the Settlement Distribution Scheme).

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

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

For instructions on who can witness your statutory declaration, visit Victorian Department of  
Justice and Community Safety:

<https://www.justice.vic.gov.au/statdecs>