STATE OF NEW YORK

SUPREME COURT COUNTY OF [Insert County]

[Insert Caption]	PLAINTIFF'S COMBINED DISCOVERY DEMANDS AND NOTICE FOR DISCOVERY AND INSPECTION IN MEDICAL MALPRACTICE CASE[1]
Plaintiff,	
vs.	
	Index No:
Defendant.	RJI No:

COMBINED DISCOVERY DEMANDS

To: Defendant {Insert Name of Defendant]

NOTICE TO PRODUCE

PLEASE TAKE NOTICE, that the undersigned demands that you produce, within twenty-one days from the date of service hereof, at the offices of Powers & Santola, LLP, 39 N. Pearl St., 2nd Floor, Albany, New York, for copying, testing or photographing by the plaintiffs, or someone acting on the plaintiffs' behalf, the following **original** documents or items that are in the possession, custody or control of said defendant:

Definitions

1. "Document" includes images, applications summaries, data, electronic mail, compilations, and information of any kind or description however made, produced, or reproduced, or stored whether

1 This is a broad notice for discovery and inspection for medical malpractice contained within a standard notice of combined demands. The notice must be tailored to fit a particular case, as it is unlikely (but possible) that all of the items requested would present in any specific case.

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by hand or by any electronic, photographic, magnetic, optical, mechanical, computer, or other process technology. A document can take the form of any medium on which information can be stored, including without limitation, computer memory, computer disk, film, paper, tape recordings, video tapes, and video disks, hard drives, servers, CDs, DVDs, zip discs, and jump drives.

2. "Document" also includes meta data, system data, backup data, files deleted by a computer user, residual data, on line storage media, and near line storage media.
3. "Document" also includes computerized data, i.e. a data compilation from which information can be obtained and translated by the responding party, if necessary, through detection devices in reasonably usable form.
4. "Document" also includes all diskettes created or used by defendant's employees that may have been maintained independently or discrete from the defendant's electronic data systems.

Instructions

1. When producing documents, if maintained in an electronic format or presently in an electronic format, these shall be produced in electronic format. This includes producing documents which were provided to outside entities, outside persons or internally in electronic format. Electronic information should be produced in commonly available PC format such as Microsoft Office Suite. If a file was maintained in a format compatible with commonly available PC software, it should be produced in the format in which it was maintained. For example, databases should be produced in either Microsoft Assess Format or Comodore Delimited ASCII; spreadsheet files; presentations should be produced as Microsoft Power Point or comparable format.
2. Because of variables which may exist in electronic production, plaintiff is willing to and requests a "meet and confer" session to work out the protocols and variables between those responsible for production of the electronic information and plaintiff's representative before production.
3. Plaintiff requests that image copies be made of the residual data, and/or that plaintiff's ability to create an image copy of the data produced be preserved.

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4. If raw data are produced, appropriate applications, file structures, manuals, and other tools necessary for the proper translation and use of the data must be provided to plaintiff(s).
5. Files (such as e-mail) for which metadata is essential for the understanding of the primary data must be identified and produced in the appropriate format.
6. Dynamic data should be produced in a native format, or in a modified format in which the integrity of the data can be maintained while the data can be manipulated for analysis.

Documents

1. Any films, images, photographs, video and audio tapes, including transcripts or memoranda thereof, involving a person referred to in paragraph one of subdivision (a) of CPLR Section 3101. There shall be disclosure of all portions of such material, including out-takes, rather than just those portions which a party intends to use. This demand shall not apply to materials compiled for law enforcement purposes, which are exempt from disclosure under section eighty-seven of the Public Officers Law. This is a continuing demand. Should any such material come into your possession, custody or control, or into the possession, custody or control of any party you represent in this action, after the date of this demand, demand is hereby made that you produce such material at the undersigned's office for inspection and copying on the aforesaid date or twenty (20) days after you, or said party, obtain possession, custody or control of same, whichever is later[2] Should any such material come into your possession, custody or control, or into the possession, custody or control of any party you represent in this action, after the date of this demand and less than twenty (20) days before the scheduled deposition of any party or witness in this action, or less than twenty (20) days before the trial of this action is scheduled to commence, demand is hereby made that you immediately notify the attorneys making this demand, by a means and method that is calculated to provide actual and meaningful notice before the date of the scheduled deposition or trial, of the existence of all such material.

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2 *See Tran v. New Rochelle Hospital Medical Center*, 99 N.Y.2d 383 (2003).

2. Any written report of the incident that is the subject of this action prepared in the regular course of business operations or practices of any person, firm, corporation, association or other public or private entity, unless prepared by a police or peace officer for a criminal investigation or prosecution and disclosure would interfere with a criminal investigation or prosecution.
3. Any statements of plaintiffs, or plaintiffs' agents, servants, or employees, now in your possession, custody or control, or in the possession, custody or control of any party you represent in this action, whether signed or unsigned, written, transcribed or otherwise recorded and whether obtained by investigation made after the date of the occurrence and regardless of how made.
4. Any films, photographs or video tapes depicting the plaintiffs.
5. Any films, photographs or video tapes depicting the scene of the events or the individuals or instrumentality that are the subject of this action.

Request For Hospital Records and Documents

1. Electronic [specify department] logs of and concerning the plaintiff.
2. All documents created, maintained, stored, and/or accessible by the defendant hospital's data, computer, electronic and management information systems department, and via any electronic, computer, or other data mining or data access method of and concerning the care and treatment of the plaintiff at the defendant Hospital. This demand includes but is not limited to all electronic, visual, computerized, and other data generated during the care and treatment of the plaintiff at the defendant hospital.
3. Originals of the complete medical records and documents pertaining to plaintiff maintained by this defendant, including but not limited to, admission notes, history, physical examinations, physician orders, physician notes, physician opinions, physicians' progress notes, nurses notes, medication record, vital sign/intake output notes, pathology reports; x-ray reports, EKG reports, EEG reports, laboratory reports, CT scan reports, MRI reports, consultations, operative reports, consent forms, anesthesia records, recovery room records, rehabilitation therapy notes, special care units notes, discharge summary, correspondence, memoranda, and all other documents that

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this defendant has in its possession, or subject to its control, concerning the plaintiff. This demand does not seek attorney client privileged information.

4. Originals of all x-rays, EKGs, EEGs, ultrasounds, CT scans, MRIs, plain films, and other radiographic and/or diagnostic and imaging studies and/or images that this defendant has in its possession, or subject to its control, concerning the plaintiff.

5. Pursuant to CPLR 3101, the plaintiffs demand that the defendant produce the original index or indexes of written, or published or computerized policies, procedures, protocols, memoranda, by-laws, rules, regulations, guidelines, agreements or care pathways of the defendant hospital that were in effect on {date], which were applicable to any and all aspects of the care and treatment of the plaintiff, including but not limited to administrative, medical, clinical, nursing, staffing, unit specific, and department and hospital wide documents.

6. All records and documents removed and/or "thinned out" from the plaintiff's chart, including Kardex.

7. The defendant hospital's document retention policy in effect from the date of plaintiff's admission to the present.

8. The medical staff appointment list for the physician defendants.

9. Documents indicating the last known address of any persons providing care and treatment to plaintiff that are no longer employed by the defendant hospital.

10. The hospital call logs for [specify date] relating to plaintiff that indicate which calls were placed to physicians from the hospital concerning the plaintiff and all recorded information and/or other records documenting same.

11. The incident report generated by defendant hospital for relating to plaintiff required by 10 N.Y.C.R.R. 405.8.

12. The report of the investigation into the circumstances of plaintiff's injury and/or death as required by 10 N.Y.C.R.R. 405.8(d).

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13. The documents and records of the defendant Hospital of and concerning any statement of deficiency issued to defendant hospital Hospital for the care and treatment of plaintiff.
14. The defendant Hospital's response to any statement of deficiency issued to defendant hospital.
15. Written statements provided by any defendant and/or defendants' representative in this case at a peer review, quality assurance review and/or morbidity review of and concerning the plaintiff.
16. Transcripts of interviews of defendant's employees and representatives by the State Department of Health of and concerning the plaintiff.
17. Retrospective investigation reports conducted by physicians employed by and/or associated with the defendant hospital of and concerning plaintiff.
18. Maintenance, repair, inspection and operating records for [specify piece of equipment that is relevant to care] that was used in the care and treatment of plaintiff from [specify dates].
19. Warranty, instruction manuals, operating manuals and instructions, and warnings and instructions for [specify piece of equipment that is relevant to care] that was used in the care and treatment of plaintiff from [specify dates].
20. Records indicating of any equipment supplier, manufacturer, retailer, and/or provider being present concerning any aspect of the care and treatment of plaintiff, and any aspect of [specify piece of equipment] during the admission of plaintiff.

Request for Hospital Billing Records and Documents

1. Copies of the complete billing records and documents for the plaintiff, for all dates of admission or out-patient treatments at the defendant hospital's facility.
2. Copies of all records and documents of payment made by the plaintiff's health insurance company.
3. Copies of all records, and documents from the defendant hospital to plaintiff's health insurer or government entity paying for plaintiff's care.

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4. The fee schedule for the [specify Mduba practice group at issue – radiology, anesthesia, emergency medicine, agency nurses, lab work] in effect during plaintiff's admission to defendant hospital.
5. The contract between the [specify Mduba practice group at issue – radiology, anesthesia, emergency medicine, agency nurses, lab work] in effect during plaintiff's admission to defendant hospital.
6. The invoices and time records and documents from the [specify Mduba practice group at issue – radiology, anesthesia, emergency medicine, agency nurses, lab work] in effect during plaintiff's admission to defendant hospital.

Request for Hospital business and administrative and other records of plaintiff not contained in the medical hospital chart

1. All documents generated or created in the ordinary course of business of and concerning the plaintiff, including but not limited to all information and documents on the hospital's computer and electronic data bases, and all information and documents not specifically contained in the plaintiff's medical hospital chart or hospital medical records.

Request for Hospital OB/GYN records policies and documents

1. The Labor and Delivery Birthing schedule and log of births for [specify date].
2. The Hospital time book for [specify date] showing staffing on the labor and delivery ward during that time.
3. The Hospital policy, procedure, protocol allowing nurses to depart from or alter existing hospital policies as to the administration of pitocin under any circumstances.
4. The original fetal monitoring strips for the infant plaintiff.
5. The records of any request for vacuum extraction devices, and/or a technician for the birth at issue in this case.
6. The records of any equipment check for the vacuum extraction devices for the birth at issue in this case.

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7. Staffing records indicating the name of the technician who delivered the vacuum extraction device to the birth at issue in this case.

8. Hospital policies, procedures, protocols, and practices effective as of the date of the birth of the infant plaintiff for entry and creation of medical records such as the plaintiff mother's hospital chart, and in what circumstances entries could be made after the birth of the child and/or after the events that occurred.

9. The written policies and procedures for maternity and newborn services, including the professional qualifications of the obstetrical and pediatric staff, as required by 10 N.Y.C.R.R. § 405.21 (c) *General Requirements*.

10. The written policies and procedures designating the requirements for consultation with a qualified specialist, as required by 10 N.Y.C.R.R. § 405.21 (c) *General Requirements.*

11. The written policies and procedures for the establishment and implementation of rooming-in at the option of each patient, as required by 10 N.Y.C.R.R. § 405.21 (c) *General Requirements.*

12. The written policies and procedures for the daily care of maternity patients and infants which shall be implemented by the staff in the maternity and newborn service, as required by 10 N.Y.C.R.R. § 405.21 (c) *General Requirements.*

13. The written description of available options for labor, delivery and postpartum services provided to [plaintiff] as required by 10 N.Y.C.R.R. § 405.21 (c) *General Requirements.*

14. The information provided to [plaintiff] advising her of the options for treatment, care and technological support that was expected to be available at the time of labor and delivery, together with the advantages and disadvantages of each option, as required by 10 N.Y.C.R.R. § 405.21 (c) (8) *Hospital prenatal care activities.*

15. The written policies and procedures to indicate where pregnant patients with obstetrical, medical or surgical complications are to be assigned to provide for their continuous observation and care, as required by 10 N.Y.C.R.R 405.21 (d) *High risk antepartum services at Level II and III perinatal care programs.*

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16. The written protocols and procedures for the in-house transfer of patients who are evaluated as requiring a level of care other than the level being provided in the area where the patient is currently located, as required by 10 N.Y.C.R.R. 405.21 (d) *High risk antepartum services at Level II and III perinatal care programs.*

17. The standardized risk assessment criteria used by defendant hospital to evaluate a patient's condition and need for special care services which were to be adopted in writing and implemented in the form throughout the perinatal service, as required by 10 N.Y.C.R.R. § 405.21 (d) *High risk antepartum services at Level II and III perinatal care programs.*

18. The written policies and procedures that indicate the areas of responsibility of both medical and nursing personnel for normal and emergency deliveries, as required by 10 N.Y.C.R.R. 405.21 (e) *Intrapartum services.*

19. The policies and procedures for the delivery room that require regular evaluation of maternal blood pressure and pulse, both during and after delivery, and fetal heart evaluation, as required by 10 N.Y.C.R.R. 405.21 (e)(4) *Delivery.*

20. The situations designated in writing by the maternity and newborn service and the medical staff that require consultation with and/or transfer of responsibility from a certified nurse midwife or a family practice physician to an obstetrician, as required by 10 N.Y.C.R.R. 405.21 (e)(4) *Delivery*.

21. The policies and procedures developed and implemented by the hospital for the recognition and immediate skillful resuscitation of a distressed newborn, including the following, as required by 10 N.Y.C.R.R. 405.21(e)(4) *Delivery*:

    a. The designation of a physician to assume primary responsibility for the establishment of standards of care, review of practices, maintenance or appropriate drugs and training of personnel;

    b. the approval of the policies and procedures by the directors of maternity and newborn services, anesthesia, pediatrics, nursing and by the medical staff;

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c. the requirement for immediate availability of needed resuscitative equipment and personnel;

d. the presence in the delivery room of a member of the professional staff who is specifically qualified in newborn resuscitation;

e. the capability to perform short-term respiratory support, including bag and mask ventilation;

f. the procedures for the stabilization of the distressed newborn;

g. the capability to perform endotracheal intubation and umbilical vessel catheterization; and

h. the transfer agreements with the Level III perinatal programs that provide for staff training to ensure current staff competence in the procedures set forth in the preceding paragraph, and which also specify those situations that require immediate transfer rather than on-site performances of those procedures; and

i. the procedures for the preparation and transfer of the distressed newborn to a Level III perinatal care program when medically indicated.

22. Any and all pamphlets, booklets, informational sheets and/or other written materials provided to the plaintiff, in connection with the pregnancy, labor, delivery and/or post-delivery periods for plaintiff's pregnancy and delivery of the infant, plaintiff that were provided to her by, or on behalf of, defendants.

23. The policies, procedures, protocols, rules or regulations setting forth the responsibilities of the anesthesia department to provide services to obstetrical patients and/or newborns with respect to the administration of anesthesia services in connection with performing cesarean sections.

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24. The policies, procedures, protocols, rules or regulations setting forth the responsibilities of the anesthesia department to provide services to obstetrical patients and/or newborns with respect to the administration of anesthesia services in connection with the resuscitation of distressed newborns.

25. The policies, procedures and/or protocols covering the responsibility of the nursing staff in connection with tending to maternity patients, monitoring the fetal heart-rate, assessing the condition of a fetus and mother, the conditions and/or circumstances under which monitoring may be performed by auscultation, attending to newborns, and the resuscitation of a distressed newborn.

26. Any and all written instructions, recommendations, correspondence, memorandum, notes, records, handbooks, manuals or documents which set forth any policies, procedures, rules, regulations, agreements, understandings and/or protocol concerning the use of **external** fetal heart monitoring equipment at defendant hospital at the time of the birth of the infant plaintiff.

27. Any and all written instructions, recommendations, correspondence, memorandum, notes, records, handbooks, manuals or documents which set forth any policies, procedures, rules, regulations, agreements, understandings and/or protocol concerning the use of **internal** fetal heart monitoring equipment at defendant hospital at the time of the birth of the infant plaintiff.

28. Any and all written instructions, recommendations, correspondence, memorandum, notes, records, handbooks, manuals or documents which were in effect at defendant hospital at the time of the infant plaintiff's birth that set forth any policies, procedures, rules, regulations, agreements, understandings and/or protocol with regard to any type of testing done on either amniotic fluid or placental tissue following childbirth.

29. A copy of the labor log for any and all patients who presented to defendant hospital on [specify date and time range]. Names of patients may be redacted to preserve confidentiality.

30. The policies, procedures, protocol, guidelines and/or documents of defendant hospital during plaintiff's admission covering the responsibility of the nursing staff in connection with tending to

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maternity patients, monitoring the fetal heart-rate, assessing the condition of a fetus and mother, the conditions and/or circumstances under which monitoring may be performed by auscultation, attending to newborns, and the resuscitation of a distressed newborn.

31. The policies, procedures, protocol, regulations, guidelines and/or documents of defendant hospital in effect during plaintiff's admission with respect to obtaining a fetal scalp pH.

32. All policies, procedures, protocol, regulations, guidelines and/or documents of defendant hospital in effect during plaintiff's admission with respect to the utilization of vacuum extraction during delivery.

33. The policies, procedures, protocol, regulations, guidelines and/or documents of defendant hospital in effect during plaintiff's admission with respect to conducting emergency cesarean section deliveries.

34. All policies, procedures, protocol, regulations, guidelines and/or documents in effect during plaintiff's admission concerning the neonatal resuscitation of infants.

35. All policies, procedures, protocol, regulations, guidelines and/or documents in effect during plaintiff's admission with respect to determining which medical specialty (i.e., obstetrics, pediatrics, anesthesiology) was responsible for suctioning and oxygenation of an infant when neonatal resuscitation was required immediately after birth.

36. All policies, procedures, protocols, regulations, guidelines and/or documents in effect during plaintiff's admission with respect to certifying the appropriate medical specialties which were required to provide neonatal resuscitation immediately after birth.

37. Any and all tests, modules, scores, cards, records, and/or documents that was made and/or maintained by the defendant hospital with respect to any neonatal resuscitation certification issued or granted to any of the medical providers and nursing staff who attended to the infant plaintiff.

38. All policies, procedures, protocol, regulations, guidelines and/or documents of defendant hospital regard to the defendant [put in name of defendant OB] performing obstetrical services for a

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patient admitted for labor and delivery, including all protocol involving record-keeping; admission procedures; writing of orders; management of the labor and delivery; performing tests and procedures, including a scalp pH or ultrasound; the management of an obstetrical patient when meconium is observed; any requests made for medical services by a neonatal intensive care unit and/or other pediatrician; or any other rule, regulation, standard, guideline or protocol that would affect the type of, or the nature of, the obstetrical services that were provided to plaintiff and/or the infant plaintiff during the plaintiff's admission.

39. Documents identifying the specific vacuum extraction equipment that was used during the delivery of the infant plaintiff including, but not limited to, the year make, model and manufacturer.

40. Written instructions, training manuals, handbooks, guidelines, pamphlets and/or documents that were provided or available to the defendant hospital by the manufacturer of the particular make, model or brand of vacuum extraction equipment that was used in connection with the delivery of the infant plaintiff.

41. Any rule, regulations, guidelines, suggestions, memorandum, conditions or directives that were prepared by or on behalf of the defendant hospital, and that were in effect during plaintiff's admission, concerning the use of vacuum extractors by any physician, nurse or technician at defendant's hospital..

42. Any memoranda, rules, procedures, guidelines or other documents issued by the Department of Obstetrics at the defendant hospital that were in effect during plaintiff's admission concerning the use of vacuum extractors and/or similar devices including, but not limited to, "mechanical forceps" or related devices.

43. Any memoranda, rules, procedures, guidelines or documents issued by the Department of Obstetrics at the defendant hospital that were in effect during plaintiff's admission concerning the use of forceps in a vaginal delivery.

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44. Any and all written instructions, recommendations, correspondence, memorandum, notes, records, handbooks, manuals or documents that were in effect during plaintiff's admission which set forth any policies, procedures, guidelines, regulations, agreements, understandings and/or protocol with regard to the administration of pitocin to an obstetrical patient during labor .

45. Any and all written instructions, recommendations, correspondence, memorandum, notes, records, handbooks, manuals or documents that were in effect during plaintiff's admission which set forth any policies, procedures, guidelines, regulations, agreements, understandings and/or protocol with regard to the administration of narcotics or other palliative drugs to an obstetrical patient during labor.

46. Any and all written instructions, recommendations, correspondence, memorandum, notes, records, handbooks, manuals or documents that were in effect during plaintiff's admission which set forth any policies, procedures, guidelines, regulations, agreements, understandings and/or protocol with regard to the rotation and/or scheduling of staff for coverage in the Department of Obstetrics.

47. Any and all written instructions, recommendations, correspondence, memorandum, notes, records, handbooks, manuals or documents that were in effect during plaintiff's admission which set forth any policies, procedures, guidelines, regulations, agreements, understandings and/or protocol with regard to resuscitation of the neonate patient and/or monitoring of the neonate at defendant's hospital.

48. Any and all written instructions, recommendations, correspondence, memorandum, notes, records, handbooks, manuals or other documents that were in effect in during plaintiff's admission setting forth any policies, procedures, guidelines, regulations, agreements, understandings and/or protocol concerning monitoring and caring for patients in labor at defendant's hospital..

49. Any and all written instructions, recommendations, correspondence, memorandum, notes, records, handbooks, manuals or documents that were in effect during plaintiff's admission which

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set forth any policies, procedures, guidelines, regulations, agreements, understandings and/or protocol with regard to "on call" and "paging" procedures at defendant's hospital.

50. Any and all written instructions, recommendations, correspondence, memorandum, notes, records, handbooks, manuals or documents that were in effect during plaintiff's admission with regard to the handling of high-risk obstetric patients through admission, labor and delivery, including neonate care in the high-risk setting, at the defendant hospital.

51. A full and complete copy of any and all statements, testimony or documentation, in writing or any other form, made by the obstetrical physician defendants, [insert defendant names] to any hospital peer review or credentialing committee regarding the treatment provided to the plaintiffs during their admission.

52. A complete copy of any employment contract and/or written agreement in effect during plaintiffs' admission by and between the defendant hospital and the [defendant OBs and their PC.]

Request for Hospital Radiology Department Records

1. Copies of reports of all diagnostic tests done regarding plaintiff.
2. Records of any wet read of any imaging study and/or film of the plaintiff.
3. Flash cards containing interpretations of plaintiff's radiology or nuclear imaging studies.
4. Preliminary and/or non-final radiology reports for any radiographic and/or imaging services performed on plaintiff.
5. Copies of all images and documents including x-rays, CT scans, MRIs, fluoroscopic images, videotape, photographs, and/or imaging or recorded or digital images of and concerning plaintiff.
6. The archived and/or stored images of CT and MRI and x-rays of the plaintiff.
7. Typograms of the plaintiff (plain film shot before CT and MRI scans are taken).
8. Scout films.
9. The plaintiff's films, scans and other image records and documents which have not been incorporated in the medical record and which are maintained at the defendant hospital pursuant to 10 N.Y.C.R.R. 405.15(a)(5)(iii).

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10. Copies of plaintiff's nuclear medicine reports which have not been incorporated into the plaintiff's medical record as stated in 10 N.Y.C.R.R. 405.15(c)(4)(i).

11. The plaintiff's records of radiologic services including interpretations, consultations and therapy filed with the patient's record, and the duplicate copies kept in the radiology department/service, and all films, scans and other image records referenced in the patient's medical record and retained in the patient's medical record, radiology department/service or in another central location accessible to appropriate staff of the hospital, as required under 10 N.Y.C.R.R. 405.15(a)(5).

12. The index of all films and images maintained by the radiology department for the plaintiff.

13. All records of diagnostic radiologic services involving plaintiff maintained pursuant to 10 N.Y.C.R.R. 405.15(a)(1)(iii).

14. Authenticated and dated reports of nuclear medicine interpretations, consultations and procedures as required under 10 N.Y.C.R.R. 405.15(c)(4).

15. Fax confirmation sheets and telecopy cover sheets and electronic mail transmitted from the radiology department to any medical provider regarding plaintiff on [specify date].

16. All records, logs, entries and other written information or documents showing when and to whom radiology reports were sent from the defendant hospital's radiology department to any medical provider on [specify date].

17. Copies of the consent forms executed by plaintiff for any procedure performed requiring nuclear or radiology services, including injection of contrast, dye, or for such procedures such as a barium swallow.

18. Fax cover sheets, letters, electronic mail, and all communications however recorded or stored by and between the radiology department and any physician regarding radiological services performed on plaintiff on [specify date].

19. The radiology department logs for [specify date].

20. Requisition forms to the radiology department for any radiology services for the plaintiff.

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21. The request for consultation, orders and/or request for service received by the radiology department for the plaintiff, including requests by the attending practitioner for x-ray examination containing a concise statement of reasons for the examination which must be authenticated by the requestor under 10 N.Y.C.R.R. 405.15(a)(5)(i).

22. The radiology department protocols used in performing the imaging and/or radiological services for plaintiff on [insert date].

23. The radiology send log for the dates of plaintiff's service showing if any radiology images were sent to the on-call radiologist at an off site location.

24. The on-call schedule for the radiologists or other physicians required to be available to perform radiological services under 10 N.Y.C.R.R. 405.15(a)(4)(ii) on any date in which plaintiff underwent radiological services.

25. The Radiology department policy and procedure manual in effect in [insert date].

26. The radiology medical department staff by-laws and rules and regulations and committee statements of and concerning:

    a. [Specify according to facts of case];

    b. The use of off-site on-call radiology;

    c. The time frames to get a CT scan imaged, sent to the off site, on call radiologist, and for the radiologist to send back a report;

    d. The method and manner by which the on call radiologist called in his findings and to what department and individual;

    e. The sending of faxes and preliminary CT and radiology reports;

    f. Use of protocols for imaging and nuclear medicine studies;

27. The contracts between any radiology group and the hospital for provision of radiology and nuclear imaging studies at the hospital in effect when plaintiff underwent radiology services at the hospital.

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28. The billing between the radiology group and the hospital for any radiology and nuclear imaging services rendered to the plaintiff.
29. Record of payment from the hospital and/or any other entity to the radiology group for radiology services rendered to plaintiff.
30. Transcription log for the radiology department for [specify date].
31. On-call rotation schedule for the radiology department employees and radiologists for [specify date].

Hospital Emergency Room Records

1. Copies of the emergency room log for [relevant dates] with the names and addresses of patients other than plaintiff redacted.

Hospital Staffing and Administrative Records

1. The written charge nurse sheet shift report given to the charge nurse at the start of each shift for the [specify] pm shift as to the plaintiffs on [specify date].
2. Copies of the job descriptions and requirements maintained by the answering defendant for all medical personnel including emergency room nurses, triage nurses registrars, agency nurses, ward clerks, nurses aides, technicians, physicians assistants and physicians that treated the plaintiff on [insert dates.]
3. Copies of the staffing, duty, and rotation log for the [specify floor or department] on [specify date] showing the shifts worked, the number and type of medical personnel on duty, and the hours they worked.
4. The job description and limitations and protocols for graduate nurses, and nurses under orientation, and working with preceptors and/or charge nurses in effect at the time of plaintiff's admission.
5. The patient census for the [specify floor or department] on [insert dates.]
6. Staffing records, time and swipe card documents, daily schedules, employment records and documents showing the hospitalists, physicians, physician's assistants, nurses, nurses aides, unit

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secretaries, technicians, ward clerks registrars, charge nurses, nursing supervisor, nursing manager, unit medical director, and on-call hospital director for the date of plaintiff's care and treatment at the defendant [specify unit of hospital.]

Hospital Records and Policies and Procedures

1. The rules and regulations for the [specify department] department and/or committee and the criteria for holding privileges;
2. The rules and regulations for the [specify department] and/or committee and the criteria for privileges;
3. The operating procedure manuals for the [specify department] as required by 10 N.Y.C.R.R. Part 405.3(d)(6).
4. The policy and procedure books establishing objective standards of care and conduct to be followed by all practitioners granted privileges in the hospital in the service areas of [designate area of medicine] as required by 10 N.Y.C.R.R. 405.4(a)(1).
5. The criteria and procedures for determining the need for consultation with a specialist physician to provide for the diagnosis and treatment of patient conditions in accordance with generally accepted standards of patient care in the field of [designate area of medicine] as required by 10 N.Y.C.R.R. 405.4(c).
6. The job descriptions for each position classification of registered professional nurses and ancillary nursing personnel specifying standards of performance and delineating the functions, responsibilities, and specific qualifications of each classification, as required by 10 N.Y.C.R.R. 405.5(a)(3).
7. The hospital policies and procedures for prompt review and correction as necessary, of health care practitioner orders which have, or have the likely potential for having negative impact on patient care and safety and which should not be carried out as required by 10 N.Y.C.R.R. 405.5(b)(1)(iii).

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8. The written hospital, clinical, or nursing policies and procedures implementing the requirements of 10 N.Y.C.R.R. 405.5(b).

9. The Hospital policies and procedures regarding medical records as required by 10 N.Y.C.R.R. 405.10

10. The Hospital policies and procedures regarding infection control required by 10 N.Y.C.R.R. 405.11.

11. The Hospital policies and procedures regarding surgical services as required by 10 N.Y.C.R.R. 405.12.

12. Copies of the medical, administrative, nursing, emergency room, by-laws, emergency department rules and regulations, and other rules, regulations, policies, guidelines, and procedures and written standards of care and/or practice and/or competencies applicable to plaintiff during her admission of and concerning complying with the patient's bill of rights under 10 N.Y.C.R.R. 405.7;

13. Hospital policies, protocols, standard procedure, and written rules concerning the following:

    a. when and under what circumstances to contact the house supervisor on patient care issues;

    b. when and under what circumstances to contact the charge nurse on patient care issues;

    c. administration of medication [specify] according to the Hospital based [specify medication] protocol;

    d. when and under what circumstances to call a physician if a change in patient status occurs;

    e. recording of patient settings and symptoms and how and what to document in the medical chart concerning the care and treatment of a patient;

    f. The use of Kardex to summarize orders prepared by physicians;

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h. the procedure used as to how and under what circumstances to discontinue the Kardex or physician's order.

Request for Hospital Pathology Department Records and Things

1. Original recuts of all pathology slides [specify whether they are to be produced stained or unstained] [specify what specific body part] for the plaintiff.
2. The specimen log book containing entries of plaintiff's pathology specimens and/or body parts.
3. The tissue specimen slip for plaintiff's specimens.
4. The [specify body part for production].
5. The index of the pathology department's operating policy and procedure manuals.

Request for Surgical/Operating Department Records and Things

1. The electronic and/or other surgical and/or operating room log for [specify date] showing all entries of and relating to plaintiff.
2. Exemplars of Pre-printed orders on hand at the date of plaintiff's admission for the type of surgery and care that was provided to plaintiff.
3. Surgical record database entries of and concerning the plaintiff.
4. All data and documents of and concerning the plaintiff from anesthesia monitoring and vital signs monitoring equipment.
5. Telemetry monitoring data and documents of and concerning the plaintiff.
6. The on-call schedule for [surgical physicians] at the defendant hospital on [specify date].
7. The rounding schedule for [surgical physicians] for the week of [specify week].
8. The surgical packet containing the [operative instruments] and other materials used in plaintiff's procedure of [specify date].
9. The surgical schedule for [specify date].
10. The staffing surgical medical, nursing, and technician schedule for [specify date].
11. The transcription log for surgeries on [specify date].

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12. Documents indicating what surgical block periods the [individual surgical defendants] had reserved at the defendant hospital's surgical suites for the week of [specify week.]

13. The anesthesia schedule and log for the date of plaintiff's surgery.

OB Nurse Midwife House Officer and Nurse Practitioner Documents

1. [Defendant] nurse practitioner time sheets for [specify dates];

2. All records of nurse [specify name] training, course work and certifications during the six month training probationary period and all other training up through the present including, without limitation reading and interpretation of fetal heart monitoring strips, understanding of hospital protocols, and the need to comply with them.

3. The hospital, administrative, nursing, clinical, management and/or other policies, procedures, practices, and/or competencies on OB house officers in effect on [specify date].

4. The written job description, requirements, and job scope for OB house officers in effect on [specify date].

5. The OB house officer staffing calendar for [specify date] indicating what OB staff officer was on duty in labor and delivery during that time, and any records indicating his activities and locations and functions during that time.

6. The photocopied material and any other written material that Nurse [specify name] received on reading fetal heart monitoring strips before the date of plaintiff's admission.

7. The Hospital policies and protocols advising nurses on what to do if they disagreed with a physician or CNM order concerning a patient under their nursing care in effect on [specify date];

8. The Hospital copy of state regulations applicable to nursing care and practice at the hospital as of [specify date];

9. The fetal heart monitoring strips done in the [specify CNM or NP] office at the hospital on, *inter alia*, [specify dates] for the infant plaintiff.

10. The nurse midwife protocols and practice guidelines for [specify defendant CNM] work at the hospital and as a nurse midwife at the hospital, including without limitation, protocols for what

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types of births could be managed without supervision, the definition of low risk birth, the protocols for Pitocin use and whether that affected the supervision of the patient, fetal heart monitoring protocols, supervision of mid-wives by practicing physicians and the qualifications necessary for those physicians;

11. The accepted and/or standard department of obstetrics and gynecology policy and protocol and rules and regulations for the topics set forth in "155" above.

12. The personnel file for [specify CNM] as limited to the supervision agreement in effect in [specify date] and the listing of all procedures and practices that [specify CNM] was entitled to perform or had elected to limit her practice to as of [specify date].

13. The on-call schedule and the work schedule for [specify CNM] and [defendant OB] on [specify dates].

14. All written materials that [defendant CNM] used or relied on in her daily practice as of [specify date] to arrive at the working definition of what was a "non-reassuring" pattern on a fetal heart monitoring strip.

15. The written protocols set forth in Paragraph VI of the undated Nurse Practitioner/Nurse Midwife Practice Agreement, to wit:

    a. Ambulatory Obstetrics: Protocols for Nurse Midwives and Nurse Practitioners;

    b. Woman's Primary Health Care: Protocols for Practice [Specify hospital] Protocols.

16. The written document required under

    a. 10 N.Y.C.R.R. 405.2(e)(1) "the hospital shall develop and implement written policies and procedures that indicate the areas of responsibility of both medical and nursing personnel of both for normal high-risk, and emergency deliveries."

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b. the hospital's policies for chemical induction or augmentation of labor as required by 10 N.Y.C.R.R. 405.21(e)(3)(ii);

c. the Hospital's policies and procedures for allowing pitocin to be administered without a physician present as long as a house officer was in the building, if any.

17. Copies of all telephone messages left at the offices of the defendant [CNM] by the plaintiff, from [specify date].

18. Records or notes of all telephone conversations held by and between the plaintiff(s) and the defendant [CNM] from [specify date].

19. Copies of all correspondence by and between the plaintiff(s) and the defendant [CNM].

20. Any and all pamphlets, booklets, informational sheets and/or other written materials provided to the plaintiff by or on behalf of the defendant [CNM] in connection with the plaintiff's pregnancy, labor, delivery and/or post-delivery periods of her pregnancy with the infant plaintiff.

21. Any and all pamphlets, booklets, informational sheets or other written documents provided to plaintiff by the defendant [CNM], advising her of the options for medical treatment and care that were available to her by the defendant [CNM and/or defendant OB] and/or his office staff during plaintiff's prenatal care, and the labor and delivery of the infant.

22. Any and all consent forms executed by the plaintiff with respect to prenatal care and labor and delivery services that were to be provided to her by the defendant [CNM and OB].

23. Complete copies of any and all documents which were on file and/or in effect at defendant hospital on [specify date] setting forth a delineation of duties, or otherwise describing the responsibilities of the defendant [OB] and defendant [CNM].

Please take note that a statement by the defendant, or defendant's counsel, indicating that the plaintiff may already be in possession of the requested records <u>WILL NOT BE CONSIDERED RESPONSIVE TO THIS DEMAND</u>. The records itemized above must be produced by the

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defendants, irrespective of whether plaintiff(s) may have independently secured or requested copies of the same information.

PLEASE TAKE FURTHER NOTICE:

- IF THE ORIGINAL OF ANY OF THE PRECEDING ITEMS WAS AT ONE TIME IN YOUR POSSESSION, CUSTODY, OR CONTROL BUT IS NO LONGER IN YOUR POSSESSION, CUSTODY OR CONTROL, PRODUCE ALL COPIES OF SAME, TOGETHER WITH A STATEMENT SETTING FORTH THE DATE THAT THE ORIGINAL OF SAID ITEM WAS LAST IN YOUR POSSESSION, CUSTODY OR CONTROL AND THE NAME OF THE PERSON OR ENTITY TO WHOM YOU TRANSFERRED POSSESSION, CUSTODY OR CONTROL ON THAT DATE.
- IF THE ORIGINAL OF ANY OF THE PRECEDING ITEMS WAS NEVER IN YOUR POSSESSION, CUSTODY, OR CONTROL BUT A COPY WAS IN YOUR POSSESSION, CUSTODY OR CONTROL, PRODUCE ALL COPIES OF SAME.
- IF THE ORIGINAL OF ANY OF THE PRECEDING ITEMS WAS NEVER IN YOUR POSSESSION, CUSTODY, OR CONTROL BUT A COPY WAS IN YOUR POSSESSION, CUSTODY OR CONTROL, BUT THAT COPY IS NO LONGER IN YOUR POSSESSION, CUSTODY OR CONTROL, PRODUCE A STATEMENT SETTING FORTH THE DATE THAT THE COPY OF SAID ITEM WAS LAST IN YOUR POSSESSION, CUSTODY OR CONTROL AND THE NAME OF THE PERSON OR ENTITY TO WHOM YOU TRANSFERRED POSSESSION, CUSTODY OR CONTROL ON THAT DATE.

DEMAND FOR EXPERT WITNESSES

PLEASE TAKE FURTHER NOTICE, that pursuant to Article 31, subdivision (d) of Section 3101 of the Civil Practice Law and Rules, the undersigned hereby demand that, at the date and time stated above, you:

1. Disclose in reasonable detail the qualifications of each expert witness whom you expect to call at trial.

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2. Disclose in reasonable detail the subject matter on which each expert is expected to testify.

3. Disclose in reasonable detail the substance of the facts and opinion on which each expert is expected to testify.

4. Disclose in reasonable detail a summary of the grounds for each expert's opinions.

DEMAND FOR CONTENTS OF INSURANCE AGREEMENT

PLEASE TAKE FURTHER NOTICE that, pursuant to Section 3101(f) of the CPLR, at the date and time stated above, you are hereby required to disclose the existence and contents of any insurance agreement under which any person carrying on an insurance business may be liable to satisfy part or all of a judgment which may be entered in this action or to indemnify or reimburse for payments made to satisfy the judgment by delivering to the offices of the undersigned, at the date and time stated above, a complete and accurate copy of all such insurance agreements, including all declaration pages, coverage sheets or face sheets pertaining thereto and all forms and endorsements that are a part of the insurance agreement. This demand is not limited to primary insurance agreements and specifically includes, but is not limited to, all insuring agreements in excess of, or which supplement, the primary insurance agreement.

DEMAND FOR WITNESSES

PLEASE TAKE FURTHER NOTICE, that the undersigned demands that, at the date and time stated above, you:

1. Identify the names and addresses of all persons who:
   a. were witnesses to the occurrences(s) or to the events surrounding the occurrence(s) that is the subject of this action; or
   b. were witnesses to the condition(s) that is the subject of this action; or
   c. were witnesses to plaintiff's injuries; or
   d. have knowledge of facts or information relevant to this action;

whether or not obtained by investigation made after the date of the occurrence and regardless of how you learned of the identity of such witnesses.

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DEMAND FOR A VERIFIED BILL OF PARTICULARS

PLEASE TAKE FURTHER NOTICE, that the undersigned demands that the answering defendant serve upon them within thirty (30) days, a verified Bill of Particulars of the claims alleged in said defendant's Answer, setting forth specifically and in detail the answers to the following inquiries:

[INSERT APPROPRIATE DEMAND FOR PARTICULARS ON AFFIRMATIVE DEFENSES]

PLEASE TAKE FURTHER NOTICE that, in the event of your failure to serve a verified bill of particulars, a motion will be made to preclude you from offering any evidence of the above on the trial of this action.

Dated: August 7, 2007

_____

POWERS & SANTOLA, LLP

Attorneys for Plaintiffs

Office and P.O. Address

39 North Pearl Street

Albany, New York 12207

(518) 465-5995

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STATE OF NEW YORK)

) ss.:

COUNTY OF ALBANY)

The undersigned, being duly sworn, deposes and says that a true and correct copy of the above and foregoing was mailed on , by depositing the paper, enclosed in a postpaid, properly addressed wrapper, in a post office or official depository under the exclusive care and custody of the United States post office department within the state, addressed to the following:

_____

Sworn to before me this _____ day of June, 2010.

_____

Notary Public

State of New York

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