Claim Form
Myers et al. v. Memorial Health System Marietta Memorial Hospital et al.

NAME

First Name: _____

Last Name: _____

CLAIM ID NUMBER

Claim ID: _____
(If you have it—this number is on the front of the postcard you may have received.)

CERTIFICATION

By submitting this Claim Form, I certify that I am the individual named above and I was an employee of Marietta Hospital or its affiliates at some point between October 29, 2012 to December 31, 2018.

Signature: _____ Date: _____