

REQUESTS FOR ADMISSION

- 1 Admit that the document attached as Exhibit A is a Disability Report that you signed when you applied for social security disability benefits. Yes.
- 2 Admit that you submitted the document attached as Exhibit A to the Social Security Administration when you applied for social security disability benefits. Yes

INTERROGATORIES

INTERROGATORY NO. 17: If you failed unconditionally to admit the entirety of any of the

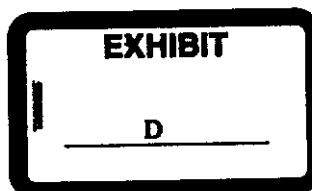
Requests for Admissions, then, as to each said Request for Admission:

- (1) Describe the reason for your answer, including the facts upon which you base your answer;
- (2) State any legal contentions upon which you base your answer;
- (3) Identify any person who has or claims to have knowledge of facts supporting or relating to your answer; and
- (4) Identify each document and/or communication that supports, refers, or relates to your answer.

I didn't fail the Requests for Admissions.

Dated this 8th day of August, 2006.

____s/ Christopher A. Roller_____
Christopher Roller (pro se)
13150 Harriet Ave. S #273
Burnsville, MN 55337
952.239.6410





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July 28, 2006

**VIA EMAIL AND UNITED
STATES MAIL**

Christopher Roller
13150 Harriet Avenue, S
#237
Burnsville MN 55337

RE: Roller v. GE Medical Systems Information

Dear Mr. Roller:

Enclosed and served upon you please find Defendant GE Medical Systems Information Technologies, Inc.'s First Set of Requests for Admissions and Second Set of Interrogatories to Plaintiff Christopher Roller.

Very truly yours,

QUARLES & BRADY LLP

A handwritten signature in black ink, appearing to read "Judith A. Williams-Killackey".

Judith A. Williams-Killackey

JKILLACK:hs
Enclosures
390086.00033

UNITED STATES DISTRICT COURT FOR THE
DISTRICT OF SOUTH DAKOTA
SOUTHERN DIVISION

CHRISTOPHER A. ROLLER,

Plaintiff,

v.

Civ. 06-04098

GE MEDICAL SYSTEMS INFORMATION
TECHNOLOGIES, INC.,

Defendant.

**DEFENDANT GE MEDICAL SYSTEMS INFORMATION TECHNOLOGIES, INC.'S
FIRST SET OF REQUESTS FOR ADMISSIONS AND SECOND SET OF
INTERROGATORIES TO PLAINTIFF CHRISTOPHER ROLLER**

TO: Christopher Roller
13150 Harriet Avenue, S, #237
Burnsville MN 55337

REQUESTS FOR ADMISSIONS

Pursuant to Federal Rule of Civil Procedure 36, Defendant GE Medical Systems Information Technologies, Inc. ("GEMS IT") serves the following Requests for Admissions and requests that Plaintiff serve a response within thirty days.

INSTRUCTIONS

1. Each Request for Admission shall be deemed continuing, so as to require amended answers should you obtain additional information subsequent to your initial answer.

2. Each of these Definitions and Instructions shall be fully applicable to each Request for Admission.
3. With respect to each Request for Admission, admissions or denials shall be based upon all information which is within the knowledge, possession, or control of you, your attorneys, agents, or other representatives.
4. All answers must be made separately and fully, and an incomplete or evasive answer may be considered to be an admission under Federal Rule of Civil Procedure 36.
5. If any of these Requests for Admission cannot be fully and unconditionally admitted or denied, after exercising due diligence to secure the full information to do so, you should provide an answer to the extent possible, specify the reason for the inability to answer the remainder, state whatever information and knowledge you have regarding the unanswered portion, and detail what you did in attempting to secure an answer to the unanswered portion.
6. If you object to fully answering a Request for Admission because of a privilege, you must nevertheless provide the following information:
 - (i) the nature of the privilege claimed (including work product);
 - (ii) if the privilege is being asserted in connection with a claim governed by state law, the state privilege rule being invoked; and
 - (iii) the general subject matter that you believe is privileged.

DEFINITIONS

1. **Communication.** The term "communication," means the transmittal of information (in the form of facts, ideas, inquiries, or otherwise).

2. Document. The term "document" is defined to be synonymous in meaning and equal in scope with the usage of this term in Fed. R. Civ. P. 34(a) and refers to the original and all non-identical copies or reproductions of any written, printed, typed, or recorded matter of any kind known to you or in your possession, custody, or control, including but not limited to:

- (i) All letters, correspondence, memoranda, telegrams, writings, instructions, calendars, desk books, records, reports, charts, studies, surveys, speeches, pamphlets, notes, drafts, proposals, minutes of meetings, microfiche, microfilm, drawings, audiotapes, audio-visual tapes, books, papers, computations, tabulations, accounting records, inter-office and intra-office communications, electronic mail communications, schedules, lists, specifications, ledgers, journals, diaries, checks, records, recordings or memoranda of conversations or any other written, printed, typewritten or other graphic or photographic matter or tangible thing on which any words or phrases are affixed, all mechanical, electronic sound or video records or transcripts thereof, all magnetic records or matter existing in any other machine-readable form, however produced or reproduced, tape or other voice records of conferences, telephone conversations, or other communications and drafts of any of the foregoing;
- (ii) Computer software, files, disks, diskettes, and tapes, and any hard copies of the information stored thereon.

It also shall include copies of such documents upon which appear any initialing, notation or handwriting of any kind not appearing on the original, whether such documents were prepared by agents or representatives of the plaintiff for their own use or for transmittal in any manner, or were received by them.

The term applies to documents wherever located, whether in the files of any agent or representative of the plaintiff or in any file whatsoever in the possession or direction or control of the plaintiff, her agents, representatives or any other person retained by the complainants.

3. Identify.

- (i) With respect to persons. When referring to a person, "to identify" means to give, to the extent known, the person's full name, present or last known address, and when referring to a natural person, additionally, the present or last known place of employment. Once a person has been identified in accordance with this subparagraph,

only the name of that person need be listed in response to subsequent discovery requesting the identification of that person.

(ii) With respect to documents. When referring to documents, "to identify" means to give, to the extent known, the:

- a. type of document;
- b. general subject matter;
- c. date of the document; and
- d. author(s), addressee(s) and recipient(s).

4. Person. The term "person" is defined as any natural person or any business, legal or governmental entity, or association.

5. "You" or "yours" means Christopher Roller.

6. "The Company" and/or GEMS IT means GE Medical Systems Information Technologies, Inc. and any related or affiliated companies, including but not limited to Micro Medical Systems.

REQUESTS FOR ADMISSION

1. Admit that the document attached as Exhibit A is a Disability Report that you signed when you applied for social security disability benefits.

2. Admit that you submitted the document attached as Exhibit A to the Social Security Administration when you applied for social security disability benefits.

SECOND SET OF INTERROGATORIES

Pursuant to Federal Rule of Civil Procedure 33, GEMS IT serves the following Interrogatories and requests that Plaintiff serve a response sworn under oath within thirty days.

INTERROGATORY INSTRUCTIONS

1. If you are unwilling to provide the requested information, totally or in part, with respect to any interrogatory, for example, but without limitation, because you claim it to be privileged, identify the privilege claimed and briefly state the grounds upon which the claim of privilege rests and nonetheless delineate the information that is being withheld so that defendant may meaningfully decide whether to move to compel production of that information.

2. With respect to each and every interrogatory, as well as each and every sub-interrogatory:

- (i) Identify all persons having knowledge concerning this subject, including without limitation, all expert witnesses, and specify the general nature of each such person's knowledge.
- (ii) Identify all documents that relate in any way to the subject.
- (iii) Identify all oral matters that relate in any way to the subject.
- (iv) Identify all persons drafting the answer to the interrogatory or any portion thereof, state by what authority they are answering the interrogatory on your behalf, describe in detail the nature and extent of the investigation engaged in that led to the answer, identify all persons contacted and all documents or files reviewed during the course of the investigation, and identify all persons from whom any of the information presented in the answer was obtained.

3. In answering these interrogatories, you are required to furnish all information that is available to you or subject to your reasonable inquiry including, but not limited to, information in the possession of your attorneys, accountants, advisors or other persons directly or indirectly employed by, or connected with, you and anyone else otherwise subject to your control.

4. In answering these interrogatories you must make a diligent search of your records and of papers and materials in your possession or available to you or your attorneys and representatives.

5. If an interrogatory has subparts, answer each part separately and in full, and do not limit your answer to the interrogatory as a whole. If any interrogatory cannot be answered in full, answer to the extent possible, specify the reason for your inability to answer the remainder, and state whatever information and knowledge you have regarding the unanswered portion.

6. The interrogatories are continuing and the answers thereto must be supplemented to the maximum extent authorized by law and the applicable rules.

INTERROGATORY DEFINITIONS

GEMS IT hereby incorporates the above Request for Admissions definitions.

INTERROGATORIES

INTERROGATORY NO. 17: If you failed unconditionally to admit the entirety of any of the Requests for Admissions, then, as to each said Request for Admission:

- (1) Describe the reason for your answer, including the facts upon which you base your answer;
- (2) State any legal contentions upon which you base your answer;
- (3) Identify any person who has or claims to have knowledge of facts supporting or relating to your answer; and
- (4) Identify each document and/or communication that supports, refers, or relates to your answer.

Dated this 28th day of July, 2006.



Judith A. Williams-Killackey (*admitted pro hac vice*)

Alexis L. Pheiffer (*admitted pro hac vice*)
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141 North Main Avenue
P.O. Box 1920
Sioux Falls, SD 57101
605.332.5999
Fax: 605.332.4249

*Attorneys for Defendant GE Medical Systems
Information Technologies, Inc.*

DISABILITY REPORT ADULT

For SSA Use Only Do not write in this box.

Related SSN Number Holder

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. NAME (First, Middle Initial, Last)

Christopher A. Roller

B. SOCIAL SECURITY NUMBER

471-96-2180

C. DAYTIME TELEPHONE NUMBER (If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)

507 637-8699 Your Number [X] Message Number [] None []

D. Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries or conditions and can help you with your claim.

NAME Cathy Roller RELATIONSHIP Mother

ADDRESS 34267 120th St. Redwood Falls MN 56283 DAYTIME PHONE 507 637-644-5555

E. What is your height without shoes?

5 feet 11 inches

F. What is your weight without shoes?

200 pounds

G. Do you have a medical assistance card? (For example, Medicaid or Medi-Cal) YES [] NO [X]

If "YES," show the number here:

I. Can you speak English? YES [X] NO [] If "NO," what languages can you speak?

If you cannot speak English, is there someone we may contact who speaks English and will give you messages? (If this is the same person as in "D" above, show "SAME" here.)

NAME RELATIONSHIP

ADDRESS: (Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

CITY STATE ZIP DAYTIME PHONE AREA CODE PHONE NUMBER

I. Can you read English? YES [X] NO [] J. Can you write more than your name in English? YES [X] NO []



A. What are the illnesses, injuries or conditions that limit your ability to work? Bipolar

How do your illnesses, injuries or conditions limit your ability to work? Can't find a job. Nobody will hire me.

C. Do your illnesses, injuries or conditions cause you pain? YES [] NO [x]

D. When did your illnesses, injuries or conditions first bother you? Month 01 Day 10 Year 1999

E. When did you become unable to work because of your illnesses, injuries or conditions? Month 02 Day 18 Year 2002

F. Have you ever worked? YES [x] NO [] (If "NO," go to Section 4.)

G. Did you work at any time after the date your illnesses, injuries or conditions first bothered you? YES [x] NO []

H. If "YES," did your illnesses, injuries or conditions cause you to: (Check all that apply.) [] work fewer hours? (Explain below.) [x] change your job duties? (Explain below.) [x] make any job-related changes such as your attendance, help needed, or employers? (Explain below.)

None

I. Are you working now? YES [] NO [x]

If "NO," when did you stop working? Month Day Year

Why did you stop working? Company fired me.

SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List all the jobs that you have had in the last 15 years that you worked.

| JOB TITLE (Example, Cook) | TYPE OF BUSINESS (Example, Restaurant) | DATES WORKED (month & year) | | HOURS PER DAY | DAYS PER WEEK | RATE OF PAY (Per hour, day week, month or year) |
|------------------------------|---|--------------------------------|-------|---------------|---------------|--|
| | | FROM | TO | | | |
| Programmer | Software | 07/99 | 7/02 | 8 | 5 | \$78,000 1yr. |
| Programmer | Software | 2/97 | 1/99 | 8 | 5 | \$ 45 1hr. |
| Programmer | " | 5/95 | 2/97 | 8 | 5 | \$ 36,000 1yr. |
| " | " | 1/92 | 6/94 | 8 | 1 | \$ 6 1hr. |
| Nuclear Electrical Eng | US Navy | 10/85 | 10/91 | 8 | 5 | \$36,000 1yr. |
| | | | | | | \$ 1 |
| | | | | | | \$ 1 |

B. Describe the job above that you did the longest. (What did you do all day in this job?)

→ Maintain & operate a nuclear power plant.

C. In this job, did you:

Use machines, tools or equipment?

YES NO

Use technical knowledge or skills?

YES NO

Do any writing, complete reports, or perform any duties like this?

YES NO

Did you supervise other people?

YES NO

If "YES," was this your main duty?

YES NO

D. In this job, how many total hours each day did you:

Walk? .25

Kneel? (Bend legs to rest on knees.) — .1

Stand? 4

Crouch? (Bend legs and back down & forward.) .1

Sit? 3

Crawl? (Move on hands & knees.) .1

Climb? .1

Handle, grab or grasp big objects? .5

Stoop? (Bend down and forward at waist.) .2

Write, type or handle small objects? 1

E. Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.)

small electrical testing equipments, once a week.

F. Check heaviest weight lifted:

Less than 10 lbs. 10 lbs. 20 lbs. 50 lbs. 100 lbs. or more Other _____

G. Check weight frequently lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

Less than 10 lbs. 10 lbs. 25 lbs. 50 lbs. or more Other _____

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

- A. Have you been seen by a doctor/hospital/clinic or anyone else for the illnesses, injuries or conditions that limit your ability to work? YES NO
- B. Have you been seen by a doctor/hospital/clinic or anyone else for emotional or mental problems that limit your ability to work? YES NO

If you answered "NO" to both of these questions, go to Section 5.

C. List other names you have used on your medical records. _____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

D. List each DOCTOR/HMO/THERAPIST. Include your next appointment.

| | | | | |
|--|--------------------|---------------------|--------------------------------|--|
| NAME <i>Dr. Mishra, (V.)</i> | | | DATES | |
| STREET ADDRESS <i>Physiatrist Services New Ulm Med. Ctr. 3rd Floor</i> | | | FIRST VISIT <i>11/2/02</i> | |
| CITY <i>New Ulm</i> | STATE <i>MN</i> | ZIP <i>56073</i> | LAST SEEN <i>5/6/03</i> | |
| PHONE <i>800 795-1211 x168</i> | CHART/HMO # | | NEXT APPOINTMENT <i>TBD</i> | |
| REASONS FOR VISITS <i>Exprexa refill.</i> | | | | |
| TREATMENT WAS RECEIVED? <i>Yes.</i> | | | | |
| NAME | | | DATES | |
| STREET ADDRESS | | | FIRST VISIT | |
| CITY | STATE | ZIP | LAST SEEN | |
| PHONE <i>Area Code Phone Number</i> | CHART/HMO # | | NEXT APPOINTMENT | |
| REASONS FOR VISITS | | | | |
| WHAT TREATMENT WAS RECEIVED? | | | | |

DOCTOR/HMO/THERAPIST

1. NAME Dr. V. Mishra DATES

STREET ADDRESS Psychiatric Services New Ulm Med Ctr Floor 3 FIRST VISIT 11/2/02

CITY New Ulm STATE MN ZIP 56073 LAST SEEN 5/6/03

PHONE 800 795-1211 x168 CHART/HMO # NEXT APPOINTMENT TBD

Area Code Phone Number

REASONS FOR VISITS Bipolar

WHAT TREATMENT WAS RECEIVED? Zyprexa

If you need more space, use Remarks, Section 9

E. List each HOSPITAL/CLINIC. include your next appointment.

1. HOSPITAL/CLINIC TYPE OF VISIT DATES

| | | | |
|---|--|------------------|-----------------|
| NAME <u>New Ulm Medical Center</u> | <input checked="" type="checkbox"/> INPATIENT STAYS (Stayed at least overnight) | DATE IN | DATE OUT |
| | | <u>11/2/02</u> | <u>11/8/02</u> |
| STREET ADDRESS <u>1217 8th North Street P.O. Box 567</u> | <input type="checkbox"/> OUTPATIENT VISITS (Sent home same day) | DATE FIRST VISIT | DATE LAST VISIT |
| | | | |
| CITY <u>New Ulm</u> STATE <u>MN</u> ZIP <u>56073</u> | <input type="checkbox"/> EMERGENCY ROOM VISITS | DATES OF VISITS | |
| | | | |
| PHONE <u>800 795-1211</u> | | | |
| Area Code Phone Number | | | |

Next appointment 5/6/03 Your hospital/clinic number 768 754

Reasons for visits I am God

What treatment did you receive? Zyprexa

What doctors do you see at this hospital/clinic on a regular basis? Dr. V. Mishra

HOSPITAL/CLINIC

| HOSPITAL/CLINIC | | TYPE OF VISIT | DATES | |
|--|--|--|------------------|-----------------|
| NAME <i>New Ulm Medical Center</i> | | <input checked="" type="checkbox"/> INPATIENT STAYS (Stayed at least overnight) | DATE IN | DATE OUT |
| STREET ADDRESS <i>1217 8th North St. P.O. Box 567 New Ulm MN 56073</i> | | | <i>6/19/99</i> | <i>6/21/99</i> |
| STATE CITY ZIP | | <input type="checkbox"/> OUTPATIENT VISITS (Sent home same day) | DATE FIRST VISIT | DATE LAST VISIT |
| PHONE <i>800 795-1211</i> <small>Area Code Phone Number</small> | | | | |
| | | <input type="checkbox"/> EMERGENCY ROOM VISITS | DATES OF VISITS | |
| | | | | |

Next appointment _____ Your hospital/clinic number _____

Reasons for visits *Think I have multiple wives*

What treatment did you receive? *Zyprexa*

What doctors do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 9

F. Does anyone else have medical records or information about your illnesses, injuries, or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

YES (If "YES," complete the information below.) NO

| NAME | | | DATES | |
|--|-------|-----|------------------|--|
| STREET ADDRESS | | | FIRST VISIT | |
| CITY | STATE | ZIP | LAST SEEN | |
| PHONE <small>Area Code Phone Number</small> | | | NEXT APPOINTMENT | |
| CLAIM NUMBER (if any) | | | | |
| REASONS FOR VISITS? | | | | |
| | | | | |

If you need more space, use Remarks, Section 9

SECTION 5 - MEDICATIONS

Do you currently take any medications for your illnesses, injuries or conditions? YES NO
 If "YES," please tell us the following: (Look at your medicine bottles, if necessary.)

| NAME OF MEDICINE | PRESCRIBED BY (Name of Doctor) | REASON FOR MEDICINE | SIDE EFFECTS YOU HAVE |
|------------------|-----------------------------------|------------------------|---------------------------|
| Zyprexa | V. Mishra | Bipolar | sleepy/loss of creativity |
| | | | |
| | | | |
| | | | |
| | | | |

If you need more space, use Remarks, Section 9

SECTION 6 - TESTS

Have you had, or will you have, any medical tests for your illnesses, injuries or conditions? YES NO If "YES," please tell us the following: (Give approximate dates, if necessary.)

| KIND OF TEST | WHEN DONE, OR WHEN WILL IT BE DONE? (Month, day, year) | WHERE DONE? (Name of Facility) | WHO SENT YOU FOR THIS TEST? |
|---------------------------------------|---|-----------------------------------|--------------------------------|
| EKG (HEART TEST) | | | |
| TREADMILL (EXERCISE TEST) | | | |
| CARDIAC CATHERIZATION | | | |
| BIOPSY Name of body part _____ | | | |
| HEARING TEST | | | |
| VISION TEST | | | |
| IQ TESTING | | | |
| EEG (BRAIN WAVE TEST) | | | |
| HIV TEST | | | |
| BLOOD TEST (NOT HIV) | | | |
| BREATHING TEST | | | |
| X-RAY Name of body part _____ | | | |
| MR/CT SCAN Name of body part _____ | | | |

If you have had any other tests, list them in Remarks, Section 9.

SECTION 7 - EDUCATION/TRAINING INFORMATION

A. Circle the highest grade of school completed.

0 1 2 3 4 5 6 7 8 9 10 11 12 GED College: 1 2 3 4 or more

Approximate date completed: _____

B. Did you attend special education classes? YES NO If "YES,"

NAME OF SCHOOL _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P. O. Box, or Rural Route)

DATES ATTENDED _____ TO _____
City State ZIP

TYPE OF PROGRAM _____

C. Have you completed any type of special job training, trade or vocational school? YES NO

If "YES," what type? US Navy Nuclear Power Training

Approximate date completed: 10/87

SECTION 8 - VOCATIONAL REHABILITATION INFORMATION

A. Have you received services from Vocational Rehabilitation or any other organization to help you get back to work? YES NO If "YES,"

NAME OF _____

NAME OF COULSELOR _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City State ZIP

DAYTIME PHONE _____
Area Code Number

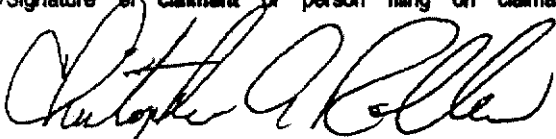
DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____
(IQ, vision, physicals, hearing, workshops, etc.)

B. Would you like to receive rehabilitation services that could help you get back to work? YES NO

SECTION 9 - REMARKS

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

| | |
|---|-------------------------|
| Signature of claimant or person filing on claimant's behalf (Parent, guardian) | Date (Month, day, year) |
|  | 7/24/2003 |

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below giving their full addresses.

| | |
|--|--|
| 1. Signature of Witness | 1. Signature of Witness |
| Address (number and street, city, state, and ZIP code) | Address (number and street, city, state, and ZIP code) |