EXHIBIT G

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE: E.I. DU PONT DE NEMOURS AND COMPANY C-8 PERSONAL INJURY LITIGATION	CASE NO. 2:13-MD-2433 JUDGE EDMUND A. SARGUS, JR. MAGISTRATE JUDGE ELIZABETH P. DEAVERS

This document relates to: **John M. Wolf v. E. I. du Pont de Nemours and Company, Case No. 2:14-cv-095.**

DECLARATION OF ROBERT A. GROSS, MD

I, Robert A. Gross, declare and state as follows:

1. I prepared the Expert Report of Robert A. Gross, MD, dated December 8, 2014 ("Expert Report") and a true and accurate copy is attached as Exhibit 1.

2. Each of the opinions in the Expert Report is stated to a reasonable degree of medical and scientific certainty, and was arrived at using reliable methods.

3. If called as a witness, I would testify competently to the matters stated in the Expert Report.

4. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: May 8, 2015

Robert A Gross MD
Robert A. Gross, MD

EXPERT REPORT
IN
John M. Wolf v. E. I. du Pont de Nemours and Company
C. A. No. 2:14-0545 (S.D. W.Va.)

Robert A. Gross, M.D.

December 8, 2014

Prepared for:
Plaintiffs' Steering Committee
In Re: E. I. du Pont de Nemours and Company
C-8 Personal Injury Litigation
Case No. 2:13-MD-2433 (S.D. Ohio)

Robert A. Gross, M.D.
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Background and Experience

I currently serve as the Director of Gastroenterology and the Gastrointestional Laboratory at Southern California Hospital of Culver City, California. I also serve as a member of the Medical Executive Committee of Southern California Hospital. I am a board-certified gastroenterologist with over 40 years of experience. I received my Bachelor of Arts degree *cum laude* from Yale University and a Doctor of Medicine degree from the University of Pennsylvania Medical School. I completed an internship and residency at Los Angeles County Hospital – Harbor General Hospital. I completed a fellowship in gastroenterology at UCLA Wadsworth VA Hospital. I am Board-certified in both Internal Medicine and in Gastroenterology, and licensed to practice medicine in California.

I served as a captain in the U.S. Air Force for two years before entering private practice in Los Angeles, California. Since 1985, I have served as an assistant clinical professor at David Geffen School of Medicine at UCLA. I joined Cedars-Sinai Medical Group in 2014. I currently serve as the Director of Gastroenterology for the Brotman Medical Center and I am on the Brotman Medical Center Medical Executive Committee. I have previously served as a vice president with the Los Angeles County Medical Association. Additionally, I am a member of the Board of Trustees at Specialty Surgical Center of Beverly Hills. I have published various articles on gastroenterological medicine including being published in the New England Journal of Medicine.

I have clinically evaluated thousands of individuals with inflammatory bowel disease. At least 50% of patients I have evaluated have been diagnosed with ulcerative colitis. Please find my curriculum vitae attached to this report as Attachment A.

Prior Testimony

A list of all other cases in which I have testified as an expert at trial or deposition during the last four years is attached as Attachment B.

Compensation

My current fees include $400.00 per hour for record review, report preparation and conferences; $750.00 per hour for depositions; and court appearance fees of $6,500.00 for a full day or $3,500 for a half day.

Methodology

I was asked to opine as to whether Mr. Wolf's exposure to perfluorooctanoic acid (hereinafter referred to as "C8") was a substantial contributing factor to the development of his ulcerative colitis. To answer this charge, I have reviewed the materials listed in Appendix C to this report, including the relevant medical records and the relevant published literature, and also conducted a physical exam of Mr. Wolf. In forming my opinions, I have utilized the standard methodology of my practice as a gastroenterologist, which includes conducting a differential diagnosis. In addition, I have relied on the work of other experts in various fields in forming my

opinions, which is my common practice in the ordinary course of my work.

Summary of Opinions

After my review of the relevant materials, the expert report of Dr. David MacIntosh, and my physical exam of Mr. Wolf, I offer the following opinions to a reasonable degree of medical and scientific certainty:

- Mr. Wolf suffers from ulcerative colitis.
- At the time of his diagnosis, both Mr. Wolf's medical records and personal history indicate he lacks potential risk factors for developing ulcerative colitis other than exposure to C8.
- Based on my review of the relevant medical records and literature, Mr. Wolf's exposure to C8 was a substantial contributing factor for his ulcerative colitis.
- As a result of his ulcerative colitis, Mr. Wolf requires continued medical care.

Etiology of Ulcerative Colitis

Based on my clinical practice and extensive experience ulcerative colitis is most always distinguishable from Crohn's Disease. Ulcerative Colitis is restricted to the colon and the rectum, and Crohn's Disease can occur in any part of the gastrointestinal tract but occurs most frequently in the small bowel. Additionally, Ulcerative Colitis affects the colonic mucosa, as opposed to Crohn's Disease which can affect all layers of the intestinal wall, and is therefore frequently described as "transmural". While approximately 10-20% of Inflammatory Bowel Disease is indeterminate, Ulcerative Colitis is properly diagnosed by colonoscopy, with associated visualization of the colonic mucosa, and sampling of the tissue with biopsy specimens, which are interpreted by a pathologist.

Ulcerative Colitis can present with varying symptoms; however, the most common are abdominal cramps, diarrhea, and rectal bleeding. Diagnostic evaluation includes physical examination, laboratory studies, and most importantly colonoscopy and biopsy. Although there are many conditions that can cause abdominal pain, for example diverticulitis, pancreatitis, or colon tumor, proper diagnostic studies can easily distinguish these conditions from Ulcerative Colitis.

The etiology of Ulcerative Colitis is controversial, although recent research is helping to unravel potential causes and associations. At present, the etiology is thought be to be multifactorial involving genetic, immunologic and environmental factors. A family incidence has been well recognized for many years and it is often stated that 10-20% of patients with Ulcerative Colitis will have at least one other family member who is affected by some form of Inflammatory Bowel Disease (Ulcerative Colitis or Crohn's Disease). Regarding the immunologic system, it is now proposed that the colonic mucosa has a constant low grade inflammation in response to environmental factors such as bacterial, chemical, or endogenous

factors. Alterations in this regulated immune system leads to the inflammation which is present in Ulcerative Colitis.

John Wolf's Medical History

Mr. Wolf, then 51 years old, initially saw gastroenterologist Dr. Anil Singh, on June 15, 2012, presenting for a screening colonoscopy.[1] Dr. Singh noted in his evaluation that Mr. Wolf had a prior history of GERD (gastroesophageal reflux disease), hyperlipidemia, and osteoarthritis. Medications included Omeprazole, Lovastatin and Propranolol. Mr. Wolf was reported to have had an Upper Gastrointestinal Endoscopy fifteen plus years ago, but to have never undergone prior colonoscopy.

Colonoscopy was scheduled for August 28, 2012. Mr. Wolf's pre-procedure diagnosis was "Screening" and his post-procedure diagnosis was "Normal Colonoscopy." In the description of procedure, Dr. Singh noted that "the patient has mild ulcerative colitis throughout the colon. The patient did have some area of sparing of the colon in the rectum and sigmoid colon. Ulceration was superficial and was consistent with ulcerative colitis. Biopsies taken from ascending colon and sigmoid colon. The patient had no involvement of terminal ileum." Dr. Singh's plan was to "start the patient on Asacol HD, await the biopsy report and follow up in our office in two to three weeks."

The Surgical Pathology Report, from Mr. Wolf's August 28, 2012 colonoscopy, indicated: "Ascending colon biopsy: colonic mucosa with chronic inflammation and diffuse acute inflammation including acute cryptitis" and "sigmoid colon biopsy: colonic mucosa with chronic inflammation and diffuse acute inflammation including acute cryptitis." The pathologist Dr. Robert J. Herceg added the following comment: "The colon biopsies show chronic colitis with diffuse somewhat superficial activity. Additionally there is a prominent eosinophilic infiltrate. The differential diagnosis includes severe acute self-limiting colitis and inflammatory bowel disease (particularly ulcerative colitis). Please correlate with clinical and colonoscopic findings. No dysplasia is seen."

On September 19, 2012, Mr. Wolf returned to Dr. Singh for a follow up appointment. Dr. Singh noted the "patient is a 51 year old male who presents with colitis. Symptoms included diarrhea. Onset was gradual. The episodes occur 2 time(s) a day. The patient describes this as mild and worsening. Symptoms are exacerbated by emotional stress. Symptoms are relieved by stress management." On physical examination Mr. Wolf's abdomen was noted to be "not tender." Assessment was "colitis (ulcerative)" and Dr. Singh's plan was to continue the previously instituted Asacol. Dr. Singh noted Mr. Wolf "is doing better with colitis. A new diagnosis of colitis was relayed to patient."

Dr. Singh reevaluated Mr. Wolf on March 21, 2013, "for his six month follow up." Dr. Singh reported that "the patient is a 52 year old man who presents for a recheck of ulcerative colitis. Symptoms include abdominal pain and diarrhea. The pain is located in the left lower

[1] Medical Records of John Wolf. [Singh (02015666) 000007 – 000022; 666538-11GTMD-00001 - 00151; 666538-17GTMD-00001 – 12; 666538-6PCA-00001 - 10]

abdomen. There is no radiation. The patient describes the pain as cramping. The patient describes this as mild and improving. Symptoms are not exacerbated by emotional stress, dietary indiscretion or missing medications. Associated symptoms do not include joint pain, nausea, vomiting visual difficulties, rash, or mouth ulcers." In his note, Dr. Singh listed his diagnosis as "colitis (ulcerative)" and medications were reported as including Asacol HD "(800 mg Tablet DR 2 Oral two times daily, taken starting 9/19/12)." Abdominal exam revealed no tenderness. Mr. Wolf was scheduled for repeat colonoscopy.

Mr. Wolf presented for his second colonoscopy on March 28, 2013. Pre-procedure diagnosis was "follow up ulcerative colitis" and post-procedure diagnosis was "ulcerative colitis." In his procedure report Dr. Singh noted that the colonoscope was "advanced up to the cecum. Cecum is identified by usual landmarks. The patient had ulcerative colitis. No active ulcerations were noted. Biopsy taken from the sigmoid colon for biopsy. Rest of exam is unremarkable." Dr. Singh's plan was to "await biopsy report and continue on Asacol. The patient will need a follow-up colonoscopy in 2 years."

The Surgical Pathology Report from Mr. Wolf's March 28, 2013 colonoscopy revealed: "sigmoid colon biopsy: colonic mucosa with no significant pathologic changes." The pathology slides were read by the same pathologist who read the biopsies of Mr. Wolf's 2012 colonoscopy, Dr. Robert J. Herceg.

Dr. Singh, in his Deposition of August 1, 2014, stated that there was a "dictation error" in his colonoscopy report of August 28, 2012, and that the post-procedure diagnosis which was listed as "normal colonoscopy" should have been "ulcerative colitis."[2] Dr. Singh also explained that the phrase in the March 28, 2013, colonoscopy report, which stated that "the patient had ulcerative colitis," was transcribed wrong and should read "the patient has ulcerative colitis."[3]

According to records from 1999 to April 3, 2014, Gary Tucker, M.D. served as Mr. Wolfe's primary physician. Mr. Wolf's initial visit to Dr. Tucker was recorded to be March 10, 1999, with a chief complaint of abdominal pain, diagnosed as most likely due to acid reflux disease. In Dr. Tucker's initial note, he reported that Mr. Wolf had a history of esophageal stricture, hiatal hernia, and GE reflux disease. Over the next several years, Mr. Wolf saw Dr. Tucker for varying problems, including shoulder/knee pain, an enlarged prostate, and seasonal allergies. On January 15, 2003, Mr. Wolf saw Dr. Tucker and at that time there was no report of abdominal pain and a stool sample was reported to be negative for occult blood. A subsequent rectal examination on January 21, 2004, was also negative for occult blood. On a subsequent visit to Dr. Tucker, a routine follow-up on February 17, 2010, rectal examination was again reported to be negative for occult blood. Dr. Tucker, on May 26, 2011, recommended to Mr. Wolf that, in view of his age, he undergo routine/preventative colonoscopy. On March 21, 2012, Dr. Tucker again recommended to Mr. Wolf that he proceed with a preventative (screening) colonoscopy, and as noted above, this examination was performed, by Dr. Singh, on March 28, 2012.

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[2] Singh Dep. 36:21-40:2, August 1, 2014.
[3] *Id.* at 54:15-55:1.

Dr. Tucker reevaluated Mr. Wolf on September 13, 2012, and, in the progress note of the visit Dr. Tucker mentioned that Mr. Wolf's recent colonoscopy revealed "ulcerative colitis." Dr. Tucker did not comment in his note regarding the presence or absence of gastrointestinal symptoms. He did, however, report, on physical examination, Mr. Wolf's abdomen was "benign" and stool was negative for occult blood.

On March 21, 2013, Dr. Tucker reevaluated Mr. Wolf in "follow-up" and reported Mr. Wolf "has ulcerative colitis. Stable on Asacol. Follows with Dr. Singh." On this visit, Dr. Tucker reported that Mr. Wolf complained of watery diarrhea, with "abdominal cramping and abdominal pain." On physical examination, Dr. Tucker reported "tenderness" and included in his assessment both gastroesophageal reflux disease and ulcerative colitis. Dr. Tucker's plan for Mr. Wolf included a follow-up with Dr. Singh on the same day. Dr. Tucker reported that Mr. Wolf was taking "Mesalamine (Asacol) 400 mg twice a day." Dr. Singh, on the same date, reported that Mr. Wolf was taking Asacol HD 800 mg, 2 tablets twice a day. This later dose, of Asacol 3.2 gm per day, would be a usual and routine dose for a patient with ulcerative colitis.

Dr. Tucker reevaluated Mr. Wolf on September 12, 2013, with a chief complaint of right leg pain. Dr. Tucker reported Mr. Wolf "complains of reflux/heartburn (controlled)." Dr. Tucker also reported that Mr. Wolf denied "abdominal pain, diarrhea....or bloody stools." On September 26, 2013, two weeks later, Mr. Wolf was reevaluated for 6 month follow up. Dr. Tucker indicates that Mr. Wolf again complains of "reflux/heartburn," but "denies...abdominal pain, diarrhea, or bloody stools." Rectal examination was normal and stool guaiac (for blood) was negative. In his note of September 26, 2013, Dr. Tucker indicates that the Mesalamine 400 mg twice a day was changed to Mesalamine (Asacol HD) 800 mg four times a day. This dosage equates to 3.2 gm per day, a typical dose for the treatment of ulcerative colitis.

Dr. Tucker again evaluated Mr. Wolf on April 3, 2014. In his report, Dr. Tucker indicates that Mr. Wolf complained of fatigue, reflux/heartburn (controlled on med), and diarrhea. Mr. Wolf reportedly denied "abdominal pain...or bloody stools." Dr. Tucker again listed Mr. Wolf's diagnoses as including "gastroesophageal reflux disease and ulcerative colitis." Prescribed medications included Mesalamine (3.2 gm/day), propranolol, lovastatin, and Omeprazole 20 mg, 1-2 per day.

Physical Examination

I conducted an evaluation of Mr. Wolf in my office in Culver City, California, prior to completing my report. During my evaluation, Mr. Wolf indicated that, prior to his colonoscopy in 2012, he was bothered for several years with significant diarrhea and cramping in the lower stomach area. Also, for several years prior to his colonoscopy he was bothered by urgent diarrhea, up to three to five times a day. Mr. Wolf describes these periods of diarrhea as urgent and states he would need to find a rest room quickly for fear of having an accident. He did have three episodes of fecal incontinence where he was not able to make it to the bathroom "in time." These occurrences of incontinence all happened prior to Mr. Wolf's 2012 colonoscopy and prior to his diagnosis of ulcerative colitis. Prior to his diagnosis of ulcerative colitis, Mr. Wolf also stated that he had observed a small amount of blood in his stools approximately one time per month. Mr. Wolf stated that he did not see Dr. Tucker regarding these symptoms prior to seeing

Dr. Singh in June 2012 because Mr. Wolf assumed his symptoms were simply the result of "getting older."

Subsequent to the diagnosis of ulcerative colitis and the institution of Asacol therapy, Mr. Wolf's symptoms of diarrhea and urgency improved. Still, Mr. Wolf experienced symptoms of diarrhea and a decrease in bowel movement number from three to five times a day to once or twice a day, on average. Mr. Wolf's fecal urgency also improved with treatment. Even with some improvement, Mr. Wolf reports that his ulcerative colitis currently significantly affects his life. Because of his continued diarrhea, he finds it necessary to know where clean rest rooms are along his delivery route. For a period of time, Mr. Wolf's medications were changed from Asacol to Apriso, and he had worsening diarrhea and abdominal pain on this newer medication as compared with the Asacol. Now, and for the last three months, he has been on Lialda, 4.8 gm per day. With Lialda his diarrhea persists, with an evacuation of approximately three bowel movements per day.

Mr. Wolf states that he generally awakens at approximately two in the morning and begins his delivery route before three. He will usually have a bowel movement prior to leaving his home but, due to urgency, finds it necessary to stop along his route to have another bowel movement. This bowel movement is very loose in consistency. Most days he will find it necessary to have a third bowel movement when he returns home. Mr. Wolf continues to have rectal bleeding with a small amount of blood on the toilet tissue approximately two times a month.

Mr. Wolf states that he believes he may be allergic to an antibiotic but is not sure of the name of this medication. He does not smoke cigarettes and drinks alcohol only one time every several months. Mr. Wolf's current medications include: (1) Lialda (mesalamine), 1.2 gm pills, 4 pills per day, (2) Omeprazole, 40 mg daily, (3) Lovastatan 20 mg daily, and (4) Propranolol 80 mg per day. He takes Ibuprofen, two pills, approximately every 3 weeks. Mr. Wolf has not had any abdominal surgery.

On Physical Examination, Mr. Wolf appears his stated age. Vital signs: BP 128/84. Heart rate 76 per minute. Respiratory rate 16 per minute. Weight is 190.6 pounds with shoes and clothes on. Sclera were not icteric. Mucus membranes of the mouth were moist. Lungs: clear to percussion and auscultation. Abdomen was soft without mass or tenderness. Shifting dullness was not noted. No mass was palpated. Rectal examination was not performed.

In summary, based on Mr Wolf's medical records and my evaluation, Mr. Wolf is a 54-year-old man who, during a screening colonoscopy in August of 2012, was diagnosed with ulcerative colitis. This diagnosis was based both on the colonoscopic appearance of Mr. Wolf's intestine with extensive "superficial ulcerations" and confirmatory findings on pathologic review of the biopsies obtained. In the pathology report, the biopsies of both the ascending colon and sigmoid colon revealed "chronic inflammation and diffuse acute inflammation" consistent with "inflammatory bowel disease (particularly ulcerative colitis)." Mr. Wolf was immediately placed on treatment for his ulcerative colitis. As is often the case, Mr. Wolf does describe typical symptoms of ulcerative colitis occurring for several years prior to the diagnosis of his disease. Before his diagnosis of ulcerative colitis, he was bothered by severe diarrhea, fecal urgency, fecal incontinence, and rectal bleeding. Mr. Wolf states his diarrhea and urgency

improved with treatment. This correlates with the healing of colonic inflammation on repeat colonoscopy. However, Mr. Wolf continues to experience symptoms of ulcerative colitis on a daily basis.

Discussion of Differential Diagnosis

For purposes of this case, I understand that C8 exposure is a cause of ulcerative colitis "among Class Members." (C8 Science Panel Probable Link Evaluation of Ulcerative Colitis)[4]. I have reviewed the expert report of Dr. David MacIntosh in this case, who is of the expert opinion that Mr. Wolf is a Class Member based on his C8 exposure[5]. It is the standard practice in my field to rely on other experts in various fields in forming a diagnosis.

There are other genetic and environmental factors that have been found to increase the risk of developing ulcerative colitis, beyond just C8.[6] The most common risk factors include infections, antibiotics, family history, genetics, medications (such as nonsteroidal anti-inflammatory drugs (NSAIDs)), and trauma. In performing a differential diagnosis I begin by ruling in each potential risk factor. After consideration of a risk factor, it is then ruled out if it is not determined to likely be a substantial contributing factor of Mr. Wolf's ulcerative colitis.

Infections, specifically *Salmonella* or *Campylobactor*, may be associated with an increased risk of ulcerative colitis. Ulcerative colitis as a result of infection is most commonly seen within one year of illness. I ruled out infection as a risk factor in Mr. Wolf's case as there is no evidence of *Salmonella* or *Campylobactor* infection in his individual history.

Antibiotics, specifically tetracyclines, are associated with a higher risk of developing ulcerative colitis. I have ruled out antibiotics as a risk factor in Mr. Wolf's case as there is no evidence he took these types of antibiotics.

Family history may be a risk factor in approximately 10-20% of patients with inflammatory bowel disease. I have ruled out family history as a risk factor for Mr. Wolf's ulcerative colitis, because Mr. Wolf has no family history of ulcerative colitis.

The role of genetic risk factors in the development of ulcerative colitis is still being elucidated. HLA-DqA1 variants may be associated with ulcerative colitis. Other genetic pathways are being evaluated. To date, however, genetic factors cannot affirmatively be established as a cause of ulcerative colitis and thus I have ruled out genetics as a cause of Mr. Wolf's ulcerative colitis.

Recently, the use of Accutane has been linked to inflammatory bowel disease, including ulcerative colitis and Crohn's disease. Per Mr. Wolf's records and my evaluation of Mr. Wolf, he has never taken Accutane. Thus, I have ruled out Accutane use as a risk factor for Mr. Wolf's ulcerative colitis.

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[4] Probable Link Evaluation of Autoimmune Disease

[5] CITE TO MCINTOSH REPORT HERE

[6] Feuerstein, Joseph D., et al., Ulcerative Colitis: Epidemiology, Diagnosis, and Management, Mayo Clinic Proceedings, Volume 89, Issue 11, Pages 1553-1563, November 2014.

This is also true of individuals of Scandinavian decent. I have ruled out these as risk factors for Mr. Wolf's ulcerative colitis as he is neither of Jewish nor Scandinavian decent.

Trauma may also be a risk factor for ulcerative colitis. Truama may cause the inflammatory response to begin and trigger ulcerative colitis. There is no evidence of trauma in Mr. Wolf's records and thus I have ruled out trauma as a cause of Mr. Wolf's ulcerative colitis in this case.

There are, at this point, other theoretical causes of ulcerative colitis, including, but not limited to, the "clean hypothesis" and microbiome alterations. The "clean hypothesis" theorizes that a cleaner society results in less exposure to disease causing agents which test the immune system. This results in individuals being more susceptible to inflammatory disease. The mirobime alteration theory claims that exposure to antibiotics results in microbime changes in the colon. According to the theory, these changes could trigger ulcerative colitis. At this point in time, both the "clean hypothesis" and microbiome alteration theories are unproven and thus I have ruled them out as causes of Mr. Wolf's ulcerative colitis.

Conclusions and Summary

Ulcerative colitis is a chronic inflammatory disease of the gastrointestinal tract that affects the large intestine. Through his treatment by Dr. Singh and Dr. Tucker, Mr. Wolf was tested for various gastrointestinal illnesses, and a diagnosis of Ulcerative Colitis was made. Diagnostic colonoscopy and biopsy, along with clinical evaluation, was necessary to document this diagnosis. Predictably, Mr. Wolf responded positively to Ulcerative Colitis treatment. Based on Mr. Wolf's medical records and all documents reviewed in preparation of my report, I conclude to a reasonable degree of medical certainty that Mr. Wolf suffers from ulcerative colitis with onset approximately in 2009.

The etiology of ulcerative colitis is frequently said to be "idiopathic," although it is now recognized that environmental factors play a role in the pathogenesis of ulcerative colitis.[7] As noted above, the C8 Science Panel has determined that there is a probable link between exposure to C8 and ulcerative colitis among Class Members.[8] As noted above, Mr. Wolf is a Class Member. Based on my standard methodology of my practice as a gastroenterologist, which includes conducting a differential diagnosis, I conclude to a reasonable degree of medical probability and certainty that Mr. Wolf's exposure to C8, also known as PFOA, is a substantial contributing factor of Mr. Wolf's ulcerative colitis.

I reserve the right to amend or modify this report as further information may become available.

Date: 12/08/2014

By: D Robert Gross MD

Dr. Robert Gross, M.D.

[7] *Id.*

[8] Probable Link Evaluation of Autoimmune Disease

ATTACHMENT A

Curriculum Vitae

CURRICULUM VITAE

Robert A. Gross, M.D.
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Education:

Bachelor of Arts	Yale University New Haven, Connecticut 1966 Cum Laude
M.D.	University of Pennsylvania Medical School Philadelphia, Pennsylvania 1970
Internship:	Los Angeles County Hospital — Harbor General Hospital 1970-1971 Rotating with Emphasis in Medicine
Residency:	Internal Medicine, Los Angeles County Hospital — Harbor General Hospital 1973-1975
Fellowship:	Fellow in Gastroenterology, UCLA Wadsworth VA Combined Program, Los Angeles, CA 1975 - 1977
Military:	Captain, United States Air Force Vandenberg Air Force Base Hospital, California 1971-1973

Academic Appointment:

Assistant Clinical Professor, UCLA, David Geffen School of Medicine 1985- Present

Certification and Licensure:

1971 Diplomate of National Board of Medical Examiners

American Board of Internal Medicine:
1975 Diplomate in Internal Medicine
1977 Diplomate in Gastroenterology

Professional Organizations/Societies:

American Gastroenterological Association
American Society for Gastrointestinal Endoscopy
American College of Gastroenterology
Southern California Society of Gastroenterology

Honors and Positions:

Los Angeles County Medical Association, District 5
Vice President, Division 2, 1988 - 1989

Brotman Medical Center

Chief-of-Staff	1990 - 1992
Vice-Chief-of-Staff	1988 - 1990
Secretary-Treasurer	1986 - 1988
Medical Excecutive Committee	1984 - present
Board of Trustees	1999 - 2002
Chairman, Gastroenterology Section	1992 - 1996
Director, Gastrointestinal Laboratory	1988 - 1992, 2000 - present
Chairman, Bylaws Committee	1988 - 1990
Chairman, Risk Management Committee	1988 - 1990

Chairman, Pharmacy and Therapeutics Committee 1984-1988

Specialty Surgical Center of Beverly Hills
Board of Trustees, 2006 - present

Hospital Affiliations:

Cedars-Sinai Medical Center, Los Angeles, California
Attending Physician 1977 - present

Brotman Medical Center, Culver City, California
Attending Physician 1977 - present

Publications:

Gross, R. A., Hogan, D.L., and Isenberg, J.I. Duodenal Acid Load and Gastric Acid Secretion are Inhibited Equally by a Fat Containing Meal in Duodenal Ulcer and Normal Subjects. Gastroenterology, 70:A 33/891, 1976. (Presented at the annual meeting of theAmerican Gastroenterological Association in Miami, May, 1976)

Gross, R.A., Hogan, D.L., Isenberg, J.I. and Samloff, I.M. The Effect of Fat on Meal - Stimulated Duodenal Acid Load, Duodenal Pepsin Load, and Serum Gastrin in Duodenal Ulcer and Normal Subjects. Gastroenterology 72:A 6/816, 1977. (Presented at the Satellite Symposium on Hormones and Ulcer, Los Angeles, October, 1976.

Peterson, W.L., Sturdevant, R.A., Frankl, H.D., Richardson, C.T., Isenberg, J.I., Elashoff, J.D., Sones, J.Q., Gross, R.A., McCallum, R.W., and Fordtran, J.S. Healing of Duodenal Ulcer with an Antacid Regimen. New England Journal of Medicine, 297: 341, 1977.

Gross, R.A., Agzarian, A. Gastrostomy - Tube Jaundice. New England Journal of Medicine, 310:51, 1987

ATTACHMENT B

Deposition and Trial Testimony

Deposition and Trial Testimony by Expert Robert Gross

Irvin Strub, M.D. v. Southern California Permanente, et al., Case No. BC355468, Los Angeles County, California Superior Court. Trial testimony, July 14, 2008

Susan Santana v. Palm Springs, et al., Case No. 11-11827-CA-06, Eleventh Judicial Circuit in and for Miami-Dade County Circuit Court. Deposition testimony, March 14, 2012

Danny Singer and Karen Gonzalez v. Patent Construction, et al., Case No. 210-cv-9707, United States District Court, Central District of California. Deposition testimony, May 10, 2012

Guadalupe Guzman, et al. v. Pacifica Hospital of the Valley, et al., Case No. , . Deposition testimony, May 23, 2012

Karen Pickett v. Chili's Bar and Grill, et al., Case No. MC022518, Los Angeles County, California Superior Court. Deposition testimony, July 25, 2012

Raul Mauricio Vasquez v. Agnes Seon Kim et al., Deposition testimony, August 21, 2012

Geoffrey Edward Haskell and Kendra Haskell v. Ralph Camarcho, Jr., M.D., et al., Case No. RD10492408, Alameda County, California Superior Court. Deposition testimony November 13, 2012

Jasvinder Kaur v. Kaiser Foundation Hospitals, Case No. OIA 11374, Binding Arbitration (no lawsuit filed). Deposition testimony, March 8, 2013, Arbitration hearing, June 20, 2013

Steger v. Michael Albertson, M.D., et al., Case No. EC052933, Los Angeles County, California Superior Court. Deposition testimony, May 6, 2013

Lisa England v. Darin S. Garner, M.D., et al., Case No. 37-2011-00059572-CU-MP-MC, San Diego County Superior Court, North County. Deposition testimony, March 3, 2014, Trial testimony May 7, 2014

Lisa Delgado v. Richard Nickowitz, M.D., Case No. GC051032, Los Angeles County, California Superior Court. Deposition testimony, August 8, 2014

ATTACHMENT C

Materials Relied On, Reviewed and/or Considered

Materials Relied On, Reviewed and/or Considered by Expert Robert Gross

All materials referenced and/or discussed within the report are incorporated. In addition to the materials within the report, the other materials relied on, reviewed, and/or considered in the preparation of the expert report are as follows:

Depositions
Deposition Transcript of John Wolf (6/12/2014), including all accompanying exhibits (*In re: E. I. Du Pont de Nemours & Company C-8 Personal Injury Litigation*, Case No. 2:13-md-2433; Wolf v. E. I. du Pont de Nemours and Company, Case No. 2:14-cv-0095)
Deposition Transcript of Gary Tucker (6/30/2004), including all accompanying exhibits (*In re: E. I. Du Pont de Nemours & Company C-8 Personal Injury Litigation*, Case No. 2:13-md-2433; Wolf v. E. I. du Pont de Nemours and Company, Case No. 2:14-cv-0095)
Deposition Transcript of Anil Singh (8/1/2004), including all accompanying exhibits *In re: E. I. Du Pont de Nemours & Company C-8 Personal Injury Litigation*, Case No. 2:13-md-2433; Wolf v. E. I. du Pont de Nemours and Company, Case No. 2:14-cv-0095)

Literature
Feuerstein, Joseph, et al., Ulcerative Colitis: Epidemiology, Diagnosis, and Management, Mayo Clinic Proceedings, Volume 89, Issue 11, Pages 1553-1563, November 2014.
Osterman, Mark T., et al., Ulcerative Colitis, Feldman: Sleisenger and Fordtran's Gastrointestinal and Liver Disease, 9th ed., pages 1975 - 1981

Documents
John Wolf medical records, Anil Singh, Bates No. Singh (02015666) 000007 – 000022
John Wolf medical records, Gary Tucker, Bates No. 666538-11GTMD-00001 – 00151 and 666538-17GTMD-00001 – 12
John Wolf medical records, Gary Tucker, Bates No. 666538-11GTMD-00001 – 00151 and 666538-17GTMD-00001 – 12
John Wolf medical records, Parkersburg Cardiology Associates, Inc., Bates No. 666538-6PCA-00001 – 10
Probable Link Evaluation of Autoimmune Disease (6/30/2012)

C8 Health Panel Records for John Wolf (Participant ID #2251)
Plaintiff Fact Sheet for John Wolf
Expert Report of Dr. David L. McIntosh