

Dear Customer,

Thank you for your interest in the *Quality of Life Study* sponsored by AMARC Enterprises Inc. in conjunction with the *Foundation for Advancement in Cancer Research*. This research study aims to gather crucial quality of life information as it pertains to Poly-MVA. Parameters such as energy, mood, efficacy and memory retention among others will be studied on a monthly basis in relation to the consumption of Poly-MVA.

Should you choose to enroll in the *Quality of Life Study* a number of benefits will be available to you. First of all, you will have the opportunity to experience the benefits thousands of customers enjoy everyday as a result of Poly-MVA. Secondly, for every month you are enrolled in the study you will be able to purchase Poly-MVA from AMARC Enterprises at a 50% discount from retail price. (your price will be \$115 per one 8 once bottle)

The Quality of Life study

Enclosed you will find a few documents that must be completed and returned to process your enrollment in the *Quality of Life Study*.

The first document is the study consent form; by signing this form you agree to the terms of the study.

The second form is the medical history questionnaire; it will be used only for statistical tracking purposes and will in no way be used to exclude you from participating in the study. Please complete this form honestly and in its entirety.

The third form is a medical records release form; by signing this form you authorize your physicians to release your medical.

Proof of diagnosis A letter from your physician or other supporting documents describing your health status must accompany your application. Example: Biopsy report, pathology report, MRI, etc.

Application must be completed within 15 days. If returning via fax please make sure you are faxing both sides of the application. Once we review the necessary documents you will be receiving an approval letter by mail. Please let us know if you decide not to participate in the study. At any time during the study if you have any questions or concerns, please do not hesitate to contact us toll free at 866-765-9682.

Study participant enrollment profile:

1. Any diagnosis or disease condition state
2. No concomitant medications or on-going treatment restrictions.
You must disclose concomitant medications and on-going treatments (both traditional western and alternative treatments).
3. Any race or gender.

Monthly questionnaires:

1. *The Monthly update questionnaire* will help us monitor any change(s) in your health from month to month.

You are required to complete the questionnaires and return to AMARC Enterprises after a month's consumption of Poly-MVA. Study length is 12 months (13 questionnaires).

- a. If returning via fax; 888-575-6880 or (619) 447-6501 (please fax both sides of questionnaires)
- b. If returning via e-mail: doctors@polymva.com
- c. If returning via mail: **1339 Broadway, EL Cajon, CA 92021**

Your answers to the questions will provide invaluable data about Poly-MVA and its effects on clients. We ask that you take your time and answer each question as accurate and honest as possible. Your responses when combined with others like yourself will provide further insight into the use, safety and quality that Poly-MVA may provide.

Thank you very much for your commitment to support and further research with Poly-MVA

Sincerely,

Director of Research
AMARC Enterprises Inc.

Quality of Life Study Informed Consent Form

To the participants in the study:

1. Introduction:

The following information describes the quality of life study and your role as a participant. Please read this carefully and do not hesitate to ask the study coordinator and/or designees any questions about this form and/or information about the study provided below.

2. Purpose of the Study:

To evaluate and determine the effects, that Poly-MVA has on a participant's quality of life. Parameters such as but not limited to: energy level, mental attitude, dosage amount, efficacy and memory retention will be evaluated.

3. Description of the Study and Procedures:

Approximately 1000 adult people in the United States will participate in this study. Enrollment in this study will last twelve (12) months, (13) questionnaires.

4. Documents required for enrollment:

- Signed and dated consent form.
- Signed and completed medical history questionnaire
- Signed and dated medical records release form.
- Signed and dated program application if applicable.
- **Approved documentation describing diagnosis.**

5. Study Summary:

Participation in this study will require the completion of the questionnaires after a month of consumption, in order to continue your participation.

PLEASE NOTE: Failure to return the monthly questionnaire may result in suspension from the study. Failure to return two monthly questionnaires will result in automatic termination.

The questionnaires will be sent (faxed, mailed, e-mailed) on a monthly basis.

- If returning via fax; 888-575-6880 or (619) 447-6501
- If returning via e-mail: doctors@polymva.com
- If returning via mail: **1339 Broadway, EL Cajon, CA 92021**

6. Discomforts and Risks:

The dietary supplement Poly-MVA used in this study may involve risks that are not known at this present time. However, you will be informed of any significant findings that might develop during the course of the study which may or may not affect your willingness to continue participation.

7. Exclusion:

There are currently no exclusions from this study.

8. Possible Benefits to Participants:

If Poly-MVA is effective, you may benefit by experiencing any of the following conditions:

- increased energy
- increased appetite
- quality of life increased memory retention
- strengthened immune system
- benefits not listed here

It is possible that no therapeutic or other direct health or quality of life benefits may result during or following the completion of this study. However, your participation will provide information about Poly-MVA that may benefit others.

9. Payment/Cost for Participation in Study

If you qualify for this study you will receive 50% off of your monthly Poly-MVA orders.

10. Compensation for Adverse Events Resulting from this study:

Financial compensation is not available for any events resulting from this study.

11. Confidentiality:

The study coordinator will keep your personal information confidential subject to all Federal regulations concerning private information. Information from this study may be submitted to the National Institute of Health, private or public Universities or research institutions or other governmental agencies. Medical records which identify you and the consent form signed by you will be inspected by the Research Department and available to be inspected by the proper governmental agencies if required. Because of this possibility to release information to these parties, absolute confidentiality cannot be guaranteed. The results of this research project may be presented at meetings or in publication; however, your identity will not be disclosed in those presentations.

12. Questions regarding this study:

You have the right to ask questions concerning this study at any time, and you are urged to do so. You will be informed of any significant new information pertaining to your safety which may modify your decision to participate in the study. If you have any questions concerning this study or need additional information about Poly-MVA please contact the research department at AMARC Enterprises toll-free at 866-765-9682.

13. Voluntary Participation and Right to Refuse or Withdraw:

Your participation in this study is voluntary. You may refuse to participate or may discontinue at any time during the duration of the study without penalty or loss of benefits to which you are otherwise entitled.

In addition, your participation may be ended by the study coordinator without regard to your consent if you become ineligible to continue in the study or if you fail to comply with the study procedures, or for any administrative or any other reasons. Your participation in the study will not affect in any way your access to purchase Poly-MVA.

INFORMED CONSENT STATEMENT:

I (NAME OF PARTICIPANT), _____
HAVE READ AND UNDERSTAND ALL THE PRECEDING INFORMATION
DESCRIBING THIS STUDY. I HAVE BEEN GIVEN THE OPPORTUNITY TO DISCUSS IT
AND ASK QUESTIONS. ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY
SATISFACTION. I VOLUNTARILY CONSENT TO PARTICIPATE IN THIS STUDY. I
WILL RECEIVE A SIGNED COPY OF THIS INFORMED CONSENT FORM.
I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO THE FOUNDATION FOR
THE ADVANCEMENT IN CANCER RESEARCH (INCLUDING ITS CONTRACTORS
AND AGENTS), AND OTHER GOVERNEMENTAL AGENCIES.

Signature of Participant

Date (MM/DD/YY)

Signature of Study Coordinator

Date (MM/DD/YY)

Personal Application for Poly-MVA Discount Program

Name: Last, First, MI _____

Street Address _____ Home # _____

City/State/Zip _____ Work # _____

E-mail _____ Date of Birth _____ Cell # _____

Fax# _____ Own _____ or Rent _____ U.S. Citizen? Yes No

Secondary Contact or Guardian _____

Phone number or email of contact _____

Best number to reach you at: _____

Best Time(s) _____ am or pm and day(s) (Circle) M-Tu-Wed- Thur-Fri- Sat- Sun

Employment:

Employer _____ Address _____

Occupation _____ Length of Employment _____

Contact _____ Phone # _____

Business Type _____

I certify under penalty of Perjury that everything I have stated on this application is true and correct. I understand you will retain this application whether or not it is approved. You are authorized to check my credit and verify current employment. In the event I fail to meet the agreement conditions with *AMARC Enterprises Inc.* The information provided above will be destroyed and it will not be sold to any third parties or be used by *AMARC Enterprises Inc.* or its affiliates for any purpose other than qualification for the "Discount Program"

Signature _____ Date _____

Spouse/Guardian Signature _____ Date _____

Medical History Questionnaire

Please print clearly or type:

Date: _____

Section 1: personal Information

Name: _____

Date of Birth (MM/DD/YR) _____ - _____ - _____ Present Weight: _____

Address: _____

City: _____ State: _____ Country _____ Zip _____

Home Phone # _____ Work Phone # _____ Other Ph # _____

Section 2: Diagnosis

_____ Date of Diagnosis: _____

Metastasis: _____

Diagnosed By (Physician's name): _____

Name of Hospital/Clinic/Office: _____

Other Information: _____

Section 3: NEW Surgery

Surgery? Y / N

If Yes please complete this section. If No, please go to Section 5.

Date of surgery: _____ Surgeon's Name: _____

Name of Hospital/Clinic/Office: _____

Outcome of Surgery: _____

Other Information: _____

Section 4: NEW Chemotherapy

Chemotherapy? Y / N

If Yes please complete this section. If No, please go to Section 6.

Type of Chemotherapy: _____ Oncologist: _____

Name of Hospital/Clinic/Office: _____

Date Started: _____ Date Ended: _____ # of Treatments _____

Section 5: NEW Radiation

Radiation? Y / N

If Yes please complete this section. If No, please go to Section 7.

Date Started:_____ Date Ended:_____

Radiologist:_____

Radiation Absorbed Dose (RADS):_____

Section 6: Alternative/ Other Therapies

Please list individually;

1. Name of Other therapy/ drug/medications:_____ Date

Started:_____ Date Ended:_____

Description/Purpose:_____

Reason for discontinuing:_____

2. Name of Other therapy/ drug/medications:_____ Date

Started:_____ Date Ended:_____

Description/Purpose:_____

Reason for discontinuing:_____

3. Name of Other therapy/ drug/medications:_____ Date

Started:_____ Date Ended:_____

Description/Purpose:_____

Reason for discontinuing:_____

4. Name of Other therapy/ drug/medications:_____ Date

Started:_____ Date Ended:_____

Description/Purpose:_____

Reason for discontinuing:_____

5. Name of Other therapy/ drug/medications:_____

Date Started:_____ Date Ended:_____

Description/Purpose:_____

Reason for discontinuing:_____

Section 7: Present Condition Karnofsky Rating (see below):_____

- 100 Normal; no complaints; no evidence of disease
- 90 Able to carry on normal activity; minor symptoms of disease
- 80 Normal activity with effort; some symptoms of disease
- 70 Cares for self; unable to carry on normal activity or active work
- 60 Requires occasional assistance but is able to care for needs
- 50 Requires considerable assistance and frequent medical care

- 40 Disabled; requires special care and assistance
- 30 Severely disabled; hospitalization is indicated death not imminent
- 20 Very sick; hospitalization necessary; active treatment is necessary
- 10 Moribund; fatal processes progressing rapidly
- 0 Dead

AUTHORIZATION FOR RESEARCH USES AND DISCLOSURES BY A COVERED HEALTH CARE PROVIDER OF PROTECTED HEALTH INFORMATION UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ADMINISTRATIVE SIMPLIFICATION SUBTITLE PRIVACY RULE (“HIPAA”)

Section 1. If you sign this Authorization, you authorize, direct and give permission to the following HIPAA Covered Entity located at the following address:

to use, disclose and release your past, current and future individually identifiable health information described in Section 3 which HIPAA calls “Protected Health Information,” to:

AMARC Enterprises Incorporated, and to the National Cancer Institute including the Best Case Series (BCS) Program in the National Cancer Institute’s Office of Cancer Complementary and Alternative Medicine (OCCAM), and to their current and future researchers, employees, consultants and contractors, and to research collaborators, research sponsors, data coordinating centers that receive and process information, Privacy Boards, Institutional Review Boards, Data Safety and Monitoring Boards; and to the current and future employees, consultants and contractors of each and all of them and all others, involved now or in the future in the Research Study (all collectively being called “Researchers”), for the Research Study described in Section 2.

Section 2.The “Research Study” is:

Collecting medical information and engaging in research regarding the experiences of individuals with Poly-MVA as an intervention for their particular cancer conditions, including presentation and review for the Best Case Series (BCS) Program in the National Cancer Institute’s (NCI) Office of Cancer Complementary and Alternative Medicine (OCCAM), and collecting such information and engaging in research regarding the effect of Poly-MVA on other degenerative diseases including heart disease and stroke, hypertension, arthritis, and multiple sclerosis, all using your Protected Health Information described in Section 3.

Section 3.The Protected Health Information that you are authorizing, directing and permitting to be used, disclosed and released for the Research Study is:

Your entire medical record and complete past, current and future patient information files maintained by Covered Entity, including information relating to your diagnosis, progression and prognosis with respect to cancer and/or regarding other degenerative diseases including heart disease and stroke, hypertension, arthritis, and multiple sclerosis, such as medical notes, pathology reports, and radiology documents and reports, quality of life information, correspondence and verbal advice the Researchers may request from Covered Entity regarding your health care and treatment which you hereby authorize, and such other information with respect to cancer and/or such other degenerative diseases as

may from time to time be requested from Covered Entity in furtherance of the Research Study; but NOT psychotherapy notes.

Section 4. Covered Entity is required by law to protect your Protected Health Information. By signing this Authorization, you authorize, direct and permit Covered Entity to use, disclose and release your Protected Health Information for the Research Study. Those persons who receive your Protected Health Information may not be required by Federal privacy laws (such as the HIPAA Privacy Rule) or other laws to protect your Protected Health Information and may share your Protected Health Information with others without your permission.

Section 5. You may change your mind, and revoke and take back, this Authorization at any time. Even if you revoke this Authorization, Covered Entity and the Researchers may still use or disclose your Protected Health Information they already have obtained, as necessary to maintain the integrity or reliability of the Research Study. To revoke this Authorization, you must write to Covered Entity at the address set forth above. If you revoke this Authorization, you may no longer be allowed to participate in the Research Study which is the subject of this Authorization. Your signature on this Authorization is voluntary: only you can decide whether or not you want to sign this Authorization. Covered Entity will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this Authorization. The Research Study will not provide you with and is not medical care or treatment.

Section 6. This Authorization does NOT have an expiration date.

By signing below, you agree that you read, understand and agree with the terms of this Authorization, and that you were given a copy of this Authorization.

X _____
Signature of Participant

Print Name of Participant or Representative

Date: _____

If applicable, INSERT below a description of the Participant's Personal Representative's authority to sign this Authorization for the Participant:
