PURDUE REGISTRATION FORM

PURDUE REGISTRATION FORM DEADLINE (the "Registration Form Deadline"): Wednesday, September 30, 2026

Please provide the following information to the Trustee (or its agents or representatives) by completing this Purdue Registration Form (this "Registration Form") and emailing it to info@purduehospitalsettlement.com prior to completing the Claim Form. Capitalized terms used herein, and not otherwise defined, shall have the meanings ascribed to them in the *Eighteenth Amended Joint Chapter 11 Plan of Reorganization of Purdue Pharma L.P. and its Affiliated Debtors* (as modified, amended or supplemented from time to time, the "Plan") [Docket No. 8233] or the Healthcare Provider Trust Distribution Procedures (as modified, amended or supplemented from time to time, the "Healthcare Provider TDP"), or the Distribution Form (as modified, amended or supplemented from time to time, the "Claim Form").

The Holder of a Healthcare Provider Channeled Claim (the "Claimant") is required to complete and submit this Registration Form and the Claim Form in order to be eligible to receive Distributions from the Healthcare Provider Trust. A Healthcare Provider Channeled Claim, as defined in the Plan, includes without limitation, (i) all Healthcare Provider Claims[1] and (ii) all Released Claims held by providers of healthcare treatment services or any social services, in their capacity as such, that are not Domestic Governmental Entities.

In this proceeding, "Purdue Opioid" means all natural, semi-synthetic or synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain, and that are approved by the U.S. Food & Drug Administration and listed by the U.S. Drug Enforcement Administration as Schedule II or III drugs pursuant to the federal Controlled Substances Act, 21 U.S.C. § 801 et seq., produced, marketed, or sold by the Debtors as: (i) the following brand name medications: OxyContin®, Hysingla ER®, Butrans®, Dilaudid®, Ryzolt, MS Contin®, MSIR®, Palladone®, DHC Plus®, OxyIR®, or OxyFast®; and (ii) the following generic medications: oxycodone extended-release tablets, buprenorphine transdermal system, hydromorphone immediate-release tablets, hydromorphone oral solution, tramadol extended-release tablets, morphine extended-release tablets, oxycodone immediate-release tablets, oxycodone and acetaminophen tablets (generic to Percocet®), hydrocodone and acetaminophen tablets (generic to Vicodin® or Norco®).

A Claimant that submits a Registration Form or Claim Form may be contacted by the Trustee (or its agents or representatives) for additional information regarding the Claim of a Holder of a Healthcare Provider Channeled Claim.

The Claim deadline is 5:00 P.M. Central Prevailing Time on Wednesday, September 30, 2026 (the "Claim Deadline"). **HOWEVER, in advance of this Claim Deadline, you must first submit this Registration Form by the Registration Form Deadline on or before Wednesday, September 30, 2026, by email to allow sufficient time for submission of all other required**

[1] A Healthcare Provider Claim as defined in the Plan includes, without limitation, (i) the Claims set forth in the approximately 1,030 Proofs of Claim filed by hospitals and the approximately 445 Proofs of Claim filed by other treatment providers (listed in Exhibit "C" of the Plan) and (ii) Claims against the Debtors held by Non-Federal Acute Care Hospitals.

documents and information required to process your Claim. Your Claim will be rejected and you will be precluded from receiving a Distribution by the Healthcare Provider Trust if this Registration Form is not received by the Registration Form Deadline. Do not send your Registration Form and Claim Form to the Court or to anyone other than the Trustee (or its agents or representatives).

A person who files a fraudulent Claim on behalf of a Holder of a Healthcare Provider Channeled Claim may, at a minimum, be fined up to $500,000.00, imprisoned for up to five years, or both, in accordance with 18 U.S.C. §§ 152, 157.

A. Claimant Information

Please provide the information in Section A.1 if you are submitting a Claim on behalf of an operating entity that owns one or more hospitals/facilities ("Operating Entity") or A.2. if you are submitting a Claim on behalf of a natural person ("Individual").

1. Operating Entity

1. Name of Operating Entity:			
2. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
3. Federal Employer Identification Number:			

2. Individual

1. Name of Individual:			
2. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
3. Social Security Number:			
4. Phone:			
5. Email:			
By filling out this Registration Form, you are deemed to consent to receipt of this notice by email.			

B. Hospital/Facility Information

Please provide the following information for the Hospital/Facility owned and/or operated by the above referenced Claimant in Section A for which this Claim is filed.

1. Name of Hospital/Facility:			
2. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
3. Duration of Ownership:	Date Acquired/Opened	Date Sold/Closed	
4. Number of Staffed Beds[2]:			

C. Contact Information

Please provide the information in Section C where notices should be sent.

1. Contact Name:			
2. Contact Title:			
3. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
4. Phone:			
5. Email:			
By filling out this Registration Form, you are deemed to consent to receipt of this notice by email.			

[2] The number of beds reported from a hospital's most recent Medicare cost report (W/S S-3, Part I, line 7 column 2). Cost report instructions define staffed beds as, "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long-term, or domiciliary areas of the hospital. Beds in labor room, birthing room, post-anesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes."

D. Attorney Information

1. Is your Holder of a Healthcare Provider Channeled Claim submitting this Registration Form with the assistance of an attorney?

☐ Yes ☐ No

If Yes, please provide the following information:

1. Attorney Contact Name:			
2. Law Firm Name:			
3. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
4. Phone:			
5. Email:			
By filling out this Registration Form, you are deemed to consent to receipt of this notice by email.			

2. Do you want any potential Distribution mailed to your attorney?

☐ Yes ☐ No

E. Payment Information

Distribution checks will be mailed to the law firm identified in Section D of this Registration Form if Yes was selected in Section D.2. If not working with an attorney, or if No was selected in Section D.2, the check will be mailed to the contact person identified in Section C of this Registration Form.

I certify that I am authorized to sign this Registration Form and I understand that an authorized signature on this Registration Form serves as an acknowledgement that I have a reasonable belief that the information is true and correct.

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

Your typed signature and submission of this Registration Form will have the same force and effect as if you signed the Registration Form on paper, which you may do alternatively.

Signature: _____

Executed on date: (MM/DD/YYYY) _____

Print the name of the person who is completing and signing this Registration Form.

Name (First, Middle, Last): _____

Title: _____

Hospital/Facility: _____

Address: _____

_____

Contact phone: _____

Email: _____