

Exhibit 17.1.28

ENROLLMENT FORM

This Enrollment Form pertains to the Settlement Agreement (“the Agreement”) dated November __, 2007, incorporated herein by reference, including but not limited to the program for resolution of claims relating to the use of Vioxx described therein (generally and collectively referred to herein as the “Resolution Program” or “the Program”).

I, the undersigned, am submitting an updated version of the spreadsheet previously submitted by me initially for Registration of Claims pursuant to Section 1.1 of the Agreement, as may have been subsequently revised or updated in connection with the terms of the Agreement and the Registration Order (“Claimant Spreadsheet”). This updated Claimant Spreadsheet identifies, *inter alia*, (i) those claims for which I am the Primary Counsel; (ii) those Eligible Claimants for whom I hereby submit this Enrollment Form, as of the date indicated below; (iii) those claims listed in the Claimant Spreadsheet previously as Claims in which I have an Interest, but in which I or other affiliated counsel no longer have an Interest, including a certification whether any remuneration was received or promised in connection with disposition of any Interest in any such Claim; and (iv) claims not previously listed on my Claimant Spreadsheet in which I did not previously, but now do, have an Interest. I hereby certify that I have undertaken to verify the accuracy of the the information contained in the spreadsheet, and that it is true and correct to the best of my knowledge and information.

I hereby represent and certify that I, or another attorney in my office, have communicated with and explained the contents of the Agreement to the individuals on whose behalf I am submitting this Enrollment Form, and that I have full authority to submit this Enrollment Form on their behalf. I further represent that I have explained to those individuals that if their Enrollment Form is accepted under the terms of the Agreement: (1) participation in the Resolution Program subjects them to the authority of those persons specified in the Agreement, including, but not limited to, the Chief Administrator, the Special Master, and any Deputy Special Masters; (2) in connection with entry into the Program they are releasing their claims against the entities and individuals identified in the attached Release (Exhibit C), and that their Release may not be returned other than under the limited circumstances provided in Section 2.7 of the Agreement; (3) enrollment terminates any lawsuits which they have brought or could have been brought, other than as provided by Section 2.7, and no claim may be advanced other than as permitted under the Agreement; (4) the Resolution Program provides their sole and exclusive remedy for their claims, and that they will be bound by its results whatever they may be, other than as may be provided for under Section 2.7 of the Agreement; and (5) the potential benefits and risks to them if they enter the Resolution Program.

I hereby agree to the terms of the Settlement Agreement. In addition, in submitting this Enrollment Form for the persons so identified on the Claimant Spreadsheet attached hereto as Attachment A, I consent and agree on their behalf, and with their full authorization, to the terms of the Agreement. As required by the Agreement, I have executed individual Stipulations of Dismissal with Prejudice (Attachment B) for these Eligible Claimants, and I submit those stipulations with this Enrollment Form. I am also submitting the Release (Attachment C) and Medical Records Authorization Form (Attachment D), each signed by the Eligible Claimant (or

their respective, duly and lawfully appointed representative). For any Eligible Claimant who is claiming past lost wages, pursuant to section 4.2 of the Agreement, I am also attaching a signed Employment Authorization Form (Attachment E) signed by that Eligible Claimant. With respect to the Medical Records Authorization and the Employment Records Authorization Form, I have advised the Eligible Claimant (or their respective, duly and lawfully appointed representative) that he or she may be asked to sign additional copies of these Authorizations or other authorizations that may be required by the Claims Administrator, Merck & Co., Inc. or providers of the records. The Eligible Claimant and I agree to cooperate fully in promptly providing any additional authorizations upon request. The Eligible Claimant and I agree to cooperate fully in promptly providing any such other form of Stipulation of Dismissal with Prejudice, if requested.

I further acknowledge that under the terms of the Agreement, no Eligible Claimant for whom I have submitted an Enrollment Form will be deemed to have been Enrolled until such time as the requirements of Section 1.2 of the Agreement have been met with respect to all claims in which I have an Interest in that (i) I have submitted an Enrollment Form for all such Eligible Claimants; or (ii) Enrollment Forms have been submitted for such Eligible Claimants by another attorney where I am not the Primary Counsel, and (iii) I have completed and executed the Certification of Final Enrollment attached hereto as Exhibit F.

ACCEPTED AND AGREED:

Dated: _____

[Plaintiffs'/Claimants' Attorney Name]

[Law Firm Name]

[Address]

[City/Town, State, Zip Code]

[Area Cod/Phone Number]

[Area Code/Fax Number]

[Email address]

ENROLLMENT FORM INSTRUCTIONS

These instructions pertain to the Enrollment Form referenced in the Settlement Agreement (“the Agreement”) dated November __, 2007, pertaining to the program for resolution of claims relating to the use of Vioxx described therein (generally and collectively referred to herein as the “Resolution Program” or “the Program”).

1. In connection with this Enrollment Form, Primary Counsel, as defined by the Registration Order, shall be designated to complete the form on behalf of each Eligible Claimant unless the Eligible Claimant is *pro se*.
2. To enroll in the Resolution Program, the following documents must be prepared, dated, signed and submitted to the Claims Administrator (collectively referred to herein as the “Enrollment Materials”). Execution copies of such documents shall be obtained from the Claims Administrator by such means as the Claims Administrator shall provide.
 - a. Completed Enrollment Form;
 - b. Claimant Spreadsheet (Attachment A).;
 - c. Stipulation of Dismissal with Prejudice (Attachment B to this Enrollment Form) for each case, properly captioned for filing with the Court where the matter is currently pending, signed by counsel for plaintiff(s) each Eligible Claimant identified as enrolling on the Claimant Spreadsheet.; and
 - d. Release (Attachment C to this Enrollment Form) signed by each Eligible Claimant (or his/her respective, duly and lawfully appointed representative) identified as enrolling on the Claimant Spreadsheet. If and if the Release is signed by a duly and lawfully appointed representative of an Eligible Claimant, said representative must indicate on each document his or her relationship to the Eligible Claimant and the authority upon which he or she is permitted to sign the document on their behalf (e.g., guardian, executor or administrator of the Estate of Eligible Claimant, etc.) and attach proper documentation (e.g., power of attorney, letters of administration) authorizing him or her to act in this representative capacity.
 - e. Medical Record Authorization Form (Attachment D to this Enrollment Form) signed by each Eligible Claimant (or his/her respective, duly and lawfully appointed representative) identified as enrolling on the Claimant Spreadsheet; and
 - f. Employment Record Authorization Form (Attachment E to this Enrollment Form) signed by each Eligible Claimant (or his/her respective, duly and lawfully appointed representative) identified as enrolling on the Claimant Spreadsheet (Attachment A) *only if* seeking past lost wages under section 4.2 of the Agreement.

ADDITIONAL INSTRUCTIONS FOR THE MEDICAL RECORDS AUTHORIZATION FORM AND EMPLOYMENT RECORD AUTHORIZATION FORM

- g. The Eligible Claimant (or their respective, duly and lawfully appointed representative) must complete the top portion of the Authorizations with the name, date of birth and social security number of the Eligible Claimant who used Vioxx and sign where indicated.
 - h. The Eligible Claimant (or their respective, duly and lawfully appointed representative) shall **LEAVE BLANK** the name and address lines for the person or entity from whom records are sought. The Eligible Claimant (or their respective, duly and lawfully appointed representative) understands that these blank lines shall be filled in by the Receiving Parties or their representatives or designated agents with the names of the healthcare providers and employers (depending on the form) identified in the Claim Form.
 - i. The Eligible Claimant (or their respective, duly and lawfully appointed representative) shall **NOT** date the Authorizations. The Eligible Claimant (or their respective, duly and lawfully appointed representative) understands that the Receiving Parties or their representatives or designated agents will date the Authorizations when the Authorizations are sent to the providers of the records.
 - j. If the Authorization are signed by duly and lawfully appointed representatives of a Eligible Claimant, said representative must describe his or her relationship to the Eligible Claimant and the authority upon which he or she is permitted to sign the Authorization on behalf of the Eligible Claimant (e.g., guardian, executor or administrator of the Estate of Eligible Claimant, etc.), where indicated on the Authorization. Said representative must also attach to the Authorization proper documentation (e.g., power of attorney, letters of administration) authorizing him or her to act in this representative capacity.
3. Submit a complete set of these Enrollment Materials to the Claims Administrator by such means as may be directed or permitted by the Claims Administrator.

ATTACHMENT B TO ENROLLMENT FORM

**TO BE COMPLETED WITH THE APPROPRIATE CAPTION FOR THE COURT
WHERE PLAINTIFF'S CLAIM IS PENDING**

XXXXX, Plaintiff(s), v. MERCK & CO., INC., Defendant(s).
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[COURT]
[DIVISION OR VENUE]

DOCKET NO. XXX

**STIPULATION OF DISMISSAL
WITH PREJUDICE
AS TO ALL DEFENDANTS**

Pursuant to [applicable Rule], the undersigned counsel hereby stipulate that all claims of plaintiffs, _____, individually and as representative of _____, against defendant Merck & Co., Inc. and all other named defendants be dismissed in their entirety with prejudice, each party to bear its own costs.

[Attorney for Plaintiff]
[Firm Name, Address and Telephone]

[Attorney for Merck & Co., Inc]
[Firm Name, Address and Telephone]

Dated: _____

Dated: _____

ATTACHMENT C TO ENROLLMENT FORM

See EXHIBIT 1.2.2.3

ATTACHMENT D TO ENROLLMENT FORM

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS PURSUANT TO 45 C.F.R. § 164.508 (HIPAA)

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Litigation Case No. _____

I hereby authorize

to release all existing medical records regarding the above-named person's medical care, treatment, physical condition, and/or medical expenses to the to _____ [Merck & Co., Inc., the Claims Administrator, the Special Master (and any Deputy Special Master) for the Program, the Chief Administrator for the Program, members of the Gate Committee for the Program, all other persons provided for under the terms of the Agreement to consider claims], and their respective attorneys, agents, servants, employees and independent auditors, the medical or other documentation required for approval of an award under the Program. These records shall be used or disclosed solely in connection with the currently pending Vioxx litigation or claims Resolution Program under the Settlement Agreement dated November ___, 2007, involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's Vioxx litigation or claim concludes. The Receiving Parties shall return or destroy the protected health information (including all copies made) at the end of the above-named person's litigation or claim.

I understand that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

This authorization also may include x-ray reports, CT scan reports, MRI scans, EEGs, EKGs, sonograms, arteriograms, discharge summaries, photographs, surgery consent forms, admission and discharge records, operation records, doctor and nurses notes (excluding psychotherapy notes maintained separately from the individual's medical record that document or

analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session by referring to something other than medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress), prescriptions, medical bills, invoices, histories, diagnoses, narratives, and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, Forms, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc.). This listing is not meant to be exclusive.

This will further authorize you to provide updated medical records, x-rays, reports or copies thereof to the above Receiving Parties until the conclusion of the litigation or claim. I understand that I have the right to revoke in writing my consent to this disclosure at any time, except to the extent that the above-named facility or provider already has taken action in reliance upon this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage. I further understand that the above-named facility or provider cannot condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient to its clients, agents, employees, consultants, experts, the court, Special Masters and others deemed necessary by the Receiving Parties to assist in this litigation or claim and may no longer be protected by HIPAA. I further reserve the right to request the return or redaction of sensitive or embarrassing information, not germane to the litigation or claim that is disclosed to the Receiving Parties.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of [Claims Administrator] or Merck & Co., Inc..

Dated this _____ day of _____, 200__

Signature: _____
[PATIENT OR REPRESENTATIVE]

Print Name: _____

If you are signing this authorization as a representative on behalf of the patient identified at the top of this form, please describe your relationship to the patient and your authority to act on his/her behalf:

You must attach proper documentation (e.g., power of attorney, letters of administration) authorizing you to act in this representative capacity.

ATTACHMENT E TO ENROLLMENT FORM

**AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS
(For claims of lost wages, earnings or earning capacity.)**

Employee's Name: _____

Date of Birth: _____

Social Security Number: _____

Litigation Case No. _____

I hereby authorize

to release all existing records and information in its possession regarding the above-named person's employment, income and education to _____ [Merck & Co., Inc., the Claims Administrator, the Special Master (and any Deputy Special Master) for the Program, the Chief Administrator for the Program, members of the Gate Committee for the Program, all other persons provided for under the terms of the Agreement to consider claims] ("Receiving Parties"). These records shall be used or disclosed solely in connection with the currently pending Vioxx litigation or claim involving the person named above. This authorization shall cease to be effective as of the date on which the above-named person's Vioxx litigation or claim concludes.

I understand that this authorization includes the above-named person's complete employment personnel file (including attendance reports, performance reports, W-4 forms, W-2 forms, medical reports, workers' compensation claims), and also includes all other records relating to employment, past and present, all records related to claims for disability, and all educational records (including those relating to courses taken, degrees obtained, and attendance records). This listing is not meant to be exclusive.

Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place. Copies of these materials are to be provided at the expense of [Claims Administrator] or Merck & Co., Inc..

Dated this _____ day of _____, 200__

Signature: _____
[*PATIENT OR REPRESENTATIVE*]

Print Name: _____

If you are signing this authorization as a representative on behalf of the employee identified at the top of this form, please describe your relationship to the employee and your authority to act on his/her behalf

You must attach proper documentation (e.g., power of attorney, letters of administration) authorizing you to act in this representative capacity.

ATTACHMENT F TO ENROLLMENT FORM

CERTIFICATION OF FINAL ENROLLMENT

This Certification of Final Enrollment pertains to the Settlement Agreement (“the Agreement”) dated November __, 2007, and Exhibit 17.1.29 to that Agreement, “Enrollment Form,” incorporated herein by reference.

In accordance with and subject to Section 1.2 of the Agreement, this certifies that I, the undersigned, have, as of the date set forth below, complied with all of the requirements of the Enrollment Form as to each Eligible Claimant for whom I serve as Primary Counsel.

In accordance with and subject to Section 1.2 of the Agreement, I further certify that all Eligible Claimants in whose claims I have a financial interest have either (i) been enrolled in the Resolution Program as claims for which I am the Primary Attorney or (ii) been enrolled in the Resolution Program by each such Eligible Claimant’s Primary Attorney for claims where I am not the Primary Attorney.

Dated: _____

[Plaintiffs’/Claimants’ Attorney Name]

[Law Firm Name]

[Address]

[City/Town, State, Zip Code]

[Area Cod/Phone Number]

[Area Code/Fax Number]

[Email address]