


UNITED STATES BANKRUPTCY COURT _____ DISTRICT OF <u>Delaware</u>		PROOF OF CLAIM
Name of Debtor <u>Women First Healthcare, INC</u>		Case Number <u>04-11278</u>
NOTE This form should not be used to make a claim for an administrative expense arising after the commencement of the case. A request for payment of an administrative expense may be filed pursuant to 11 USC § 503.		
Name of Creditor (The person or other entity to whom the debtor owes money or property) <u>Thomson Healthcare INC</u> ^{G.K.A} _{PAR}		<input type="checkbox"/> Check box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars. <input checked="" type="checkbox"/> Check box if you have never received any notices from the bankruptcy court in this case. <input type="checkbox"/> Check box if the address differs from the address on the envelope sent to you by the court.
Name and address where notices should be sent <u>Thomson Healthcare INC</u> <u>5 PARACOM Drive</u> <u>Murkula, NJ 07645</u> ^{ATTN: PAUL GERMAN} Telephone number <u>201-358-7200</u>		
Account or other number by which creditor identifies debtor <u>P9020</u>		Check here <input type="checkbox"/> replaces a previously filed claim dated _____ if this claim <input type="checkbox"/> amends _____
1 Basis for Claim <input type="checkbox"/> Goods sold <input type="checkbox"/> Services performed <input type="checkbox"/> Money loaned <input type="checkbox"/> Personal injury/wrongful death <input type="checkbox"/> Taxes <input type="checkbox"/> Other <u>AD PLACES IN PUBLICATION</u> <input type="checkbox"/> Retiree benefits as defined in 11 USC § 1114(a) <input type="checkbox"/> Wages, salaries, and compensation (fill out below) Last four digits of SS # _____ Unpaid compensation for services performed from _____ to _____ (date) (date)		
2 Date debt was incurred <u>10/03</u>		3 If court judgment, date obtained
4 Total Amount of Claim at Time Case Filed \$ <u>55,308</u> (unsecured) _____ (secured) _____ (priority) _____ <u>55,308</u> (Total) If all or part of your claim is secured or entitled to priority, also complete Item 5 or 7 below. <input type="checkbox"/> Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.		
5 Secured Claim <input type="checkbox"/> Check this box if your claim is secured by collateral (including a right of setoff). Brief Description of Collateral: <input type="checkbox"/> Real Estate <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Other _____ Value of Collateral \$ _____ Amount of arrearage and other charges at time case filed included in secured claim if any \$ _____		7 Unsecured Priority Claim <input type="checkbox"/> Check this box if you have an unsecured priority claim. Amount entitled to priority \$ _____ Specify the priority of the claim: <input type="checkbox"/> Wages, salaries, or commissions (up to \$4,925)* earned within 90 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier. 11 USC § 507(a)(3) <input type="checkbox"/> Contributions to an employee benefit plan. 11 USC § 507(a)(4) <input type="checkbox"/> Up to \$2,225* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 USC § 507(a)(6) <input type="checkbox"/> Alimony, maintenance, or support owed to a spouse, former spouse, or child. 11 USC § 507(a)(7) <input type="checkbox"/> Taxes or penalties owed to governmental units. 11 USC § 507(a)(8) <input type="checkbox"/> Other. Specify applicable paragraph of 11 USC § 507(a)(____). *Amounts are subject to adjustment on 4/1/07 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.
6 Unsecured Nonpriority Claims <u>55,308</u> <input type="checkbox"/> Check this box if: a) there is no collateral or lien securing your claim; or b) your claim exceeds the value of the property securing it; or c) none or only part of your claim is entitled to priority.		THIS SPACE IS FOR COURT USE ONLY FILED MAY 14 2004 BMC Women First Healthcare Inc 
8 Credits The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim.		
9 Supporting Documents Attach copies of supporting documents such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, explain. If the documents are voluminous, attach a summary.		
10 Date-Stamped Copy To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.		
Date <u>5/10/04</u>	Sign and print the name and title of any of the creditor or other person authorized to file this claim (attach copy of power of attorney if any). <u>PAUL GERMAN, Director of Credit</u> <i>Paul German</i>	

THOMSON

PDR

Invoice # M027794

PHYSICIANS' DESK REFERENCE
P O BOX 95179
CHICAGO IL 60694-5179
Phone 201-358 -7200

Invoice Date 10/16/2003
Client # P9020

Bill To

WOMEN'S FIRST HEALTHCARE
ATTN CHARLENE TAYLOR, ACCTS PAYABLE
5355 MIRA SORRENTO PLACE
SUITE 700
SAN DIEGO CA 92121

W-9 Information The Provider of Goods and
Services listed on this Invoice is a Division of
Thomson Healthcare Inc
TIN/EIN # is 59-2811463

Terms Net 30 Days

Shipment Terms F O B Shipping Point

Client Code	Publication Code	Purchase Order	Page #
P9020	PDR	Not On File	1

PHYSICIANS DESK REFERENCE 2004

<u>Description</u>	<u>Amount</u>
9 PAGES @ \$ 324 67 /INCH	96 412 14
11 528" ADDITIONAL INCHES @ \$ 324 62	3 742 21
7 GRIDS @ \$ 1461 66	10 231 62
SEPARATION CHARGES	230 00

PLEASE NOTE The Corporate Discount for combination billing has been
applied Total amount due is \$ 110 615 97 Without the added benefit
of combination billing the total bill would be \$ 163 606 32

ADVERTISING SPACE FOR

WOMEN S FIRST HEALTHCARE
5355 MIRA SORRENTO PLACE
SUITE 700
SAN DIEGO CA 92121
ATTENTION CHARLENE TAYLOR ACCTS PAYABLE

*Wire Transfer Information Harris Trust and Savings Bank Chicago ILL USA
ABA 0710-0028-8 Beneficiary 339-072-1 Thomson Healthcare Inc*

Continued

Detach and return this stub with your payment Please show Invoice Number on your check

Remit To THOMSON HEALTHCARE INC P O BOX 95179 CHICAGO IL 60694-5179	Bill To WOMEN S FIRST HEALTHCARE ATTN CHARLENE TAYLOR ACCTS PAYABLE 5355 MIRA SORRENTO PLACE SUITE 700	Invoice # M027794 Client # P9020 Invoice Date 10/16/2003 Invoice Total USD \$ Continued
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PHYSICIANS DESK REFERENCE 2004

Description

Amount

PLEASE PROVIDE COMPLETE INVOICE NUMBERS WITH EACH WIRE TRANSFER

PLEASE NOTE OUR NEW COMPANY NAME IS THOMSON HEALTHCARE INC

INVOICE SUMMARY
 Balance Due \$ 55,308
 PLEASE REMIT

55,307.97
paid 12/13/03

Invoice Total USD \$

110,615.97

Detach and return this stub with your payment Please show Invoice Number on your check

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