


UNITED STATES BANKRUPTCY COURT _____ District of DELAWARE		PROOF OF CLAIM
Name of Debtor WOMEN FIRST HEALTHCARE INC		Case Number 04-11278
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 U.S.C. § 503.		
Name of Creditor (The person or other entity to whom the debtor owes money or property) ACCOUNTEMPS		<div style="font-size: 2em; font-weight: bold;">REC'D JUN 03 2004</div> This Space is for Court Use Only
Name and address where notices should be sent DIV OF ROBERT HALF INTERNATIONAL 5720 STONERIDGE DRIVE, SUITE THREE PLEASANTON, CA 94588 ATTN KAREN LIMA Telephone number 925-598-7844		
<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 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.		
Account or other number by which creditor identifies debtor 00400-001372-000		Check here <input type="checkbox"/> replaces if this claim <input type="checkbox"/> amends a previously filed claim dated _____
1 BASIS FOR CLAIM <input type="checkbox"/> Goods sold <input checked="" type="checkbox"/> Services performed <input type="checkbox"/> Money loaned <input type="checkbox"/> Personal injury/wrongful death <input type="checkbox"/> Taxes <input type="checkbox"/> Other _____ <input type="checkbox"/> Retiree benefits as defined in 11 U.S.C. § 1114 (a) <input type="checkbox"/> Wages, salaries, and compensations (fill out below) Your SS # _____ Unpaid compensation for services performed from _____ (date) to _____ (date)		
2 Date debt was incurred 12/15/03 THROUGH 1/19/04		3 If court judgment, date obtained
4 Total Amount of Claim at Time Case Filed \$ 5,887.70 If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 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 \$ _____		6 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 \$4300) earned within 90 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier. 11 U.S.C. § 507(a)(3) <input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(4) <input type="checkbox"/> Up to \$1,950* of deposits toward purchase, lease, or rental of property or services for personal family or household use. 11 U.S.C. § 507(a)(6) <input type="checkbox"/> Alimony, maintenance, or support owed to a spouse, former spouse, or child. 11 U.S.C. § 507(a)(7) <input type="checkbox"/> Taxes or penalties of governmental units. 11 U.S.C. § 507(a)(8) <input type="checkbox"/> Other. Specify applicable paragraph of 11 U.S.C. § 507(a) _____ *Amounts are subject to adjustment on 4/1/98 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.
7 CREDITS The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim. 8 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. 9 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.		This Space is for Court Use Only <div style="text-align: right;"> Women First Healthcare Inc  00013 </div>
Date 5/20/04	Sign and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any). KAREN LIMA, RECOVERY MANAGER	
Penalty for presenting fraudulent claim: Fine of up to \$500,000 or imprisonment for up to 5 years, or both.		

Report ID AR30003
 Aging Id MAIN /STD
 Currency Base Currency
 Rate Type

Robert Half International
 Aging Detail by Business Unit
 as of 20 MAY 2004

Page No 1
 Run Date 05/20/2004
 Run Time 14 56 23

Item	Line	As Of	Ent Typ/Rsn	Terms	Document	Cur Amount	Future	1 30	31 60	61 90	91 120	Other
TATUS 00400 001372WOMEN FIRST HEALTHCARE INC SAN DIEGO CA												
10335195	1	12/15/2003	EXDR	REG	IMMED N	USD	828 16					828 16
10335195	2	12/15/2003	EXDR	OVT	IMMED N	USD	135 87					135 87
10373009	1	12/22/2003	EXDR	REG	IMMED N	USD	1 035 20					1 035 20
10373009	2	12/22/2003	EXDR	OVT	IMMED N	USD	252 33					252 33
10400894	1	12/29/2003	EXDR	REG	IMMED N	USD	1 035 20					1 035 20
10423871	1	01/05/2004	EXDR	REG	IMMED N	USD	750 52					750 52
10474593	1	01/13/2004	EXDR	REG	IMMED N	USD	1 035 20					1 035 20
10474593	2	01/13/2004	EXDR	OVT	IMMED N	USD	19 41					19 41
10501664	1	01/19/2004	EXDR	REG	IMMED N	USD	776 40					776 40
10501664	2	01/19/2004	EXDR	OVT	IMMED N	USD	19 41					19 41
Total WOMEN FIRST HEALTHCARE INC							5 887 70					5 887 70
Total TATUS							5 887 70					5 887 70