



ANNUAL REPORT OF REPRESENTED ENTITY

NEW JERSEY ELECTION LAW ENFORCEMENT COMMISSION
P.O. Box 185, Trenton, NJ 08625-0185
(609) 292-8700 or Toll Free Within NJ 1-888-313-ELEC (3532)
Website: www.elec.state.nj.us

FORM L1-L Reporting For Calendar Year 2010

ELEC RECEIVED MAR 04 2011

FOR STATE USE ONLY

Amendment [checked]

Name of Represented Entity Merck Sharp & Dohme Corporation and its affiliates

Business Address c/o 2350 Kerner Blvd., Suite 250

City San Rafael State CA Zip Code 94901

\*(Area Code) Telephone Number

1. Provide the following information regarding the Governmental Affairs Agent(s) employed by the Represented Entity named above.

1. Name Robert Silberg

Registration Number 1153-1 Job Title Director, Government Affairs

Business Address 3126 Cloverly Drive

City Furlong State PA Zip Code 18925

\*(Area Code) Telephone Number (215) 345-4028

2. Name Bindi Patel

Registration Number 1758-1 Job Title Policy Manager: MVID

Business Address 1551 Sansom St. Apt 500

City Philadelphia State PA Zip Code 19102

\*(Area Code) Telephone Number (215) 563-0131

3. Name N/A

Registration Number Job Title

Business Address

City State Zip Code

\*(Area Code) Telephone Number

4. Name N/A

Registration Number Job Title

Business Address

City State Zip Code

\*(Area Code) Telephone Number

\*Leave this field blank if your telephone number is unlisted. Pursuant to N.J.S.A. 47:1A-1.1, an unlisted telephone number is not a public record and must not be provided on this form.

**SCHEDULE G-1****ITEMIZATION OF BENEFITS WHICH EXCEEDED \$25 PER DAY OR \$200 PER CALENDAR YEAR TO STATE OFFICIALS AND THEIR IMMEDIATE FAMILY MEMBERS**

**PURPOSE:** To report detailed information concerning benefits passed to State officials covered by the Act, as well as the immediate family members of these officials. If the value of a benefit exceeded \$25 per day or \$200 per calendar year, report below.

*(Select one description item for each entry from the drop down list. When selecting "O - Other", enter a description in the space provided.)*

Name of Benefit Recipient Dr. Katherine Hemstead, Director of NJ Dept. of Health & Senior Services  
 Date 3/17/2010 Description T - Travel Amount \$ 200.00

Name and Address of Payee/Vendor  
 Name King Limousine & Transportation  
 Address 3490 US Highway 1 Suite 11-2  
 City Princeton State NJ Zip Code 08540

If benefit was reimbursed, please report the date, the description, and the amount of the reimbursement.

Date \_\_\_\_\_ Amount \$ \_\_\_\_\_  
 Description \_\_\_\_\_

Name of Benefit Recipient \_\_\_\_\_  
 Date \_\_\_\_\_ Description \_\_\_\_\_ Amount \$ \_\_\_\_\_

Name and Address of Payee/Vendor  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

If benefit was reimbursed, please report the date, the description, and the amount of the reimbursement.

Date \_\_\_\_\_ Amount \$ \_\_\_\_\_  
 Description \_\_\_\_\_

Name of Benefit Recipient \_\_\_\_\_  
 Date \_\_\_\_\_ Description \_\_\_\_\_ Amount \$ \_\_\_\_\_

Name and Address of Payee/Vendor  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

If benefit was reimbursed, please report the date, the description, and the amount of the reimbursement.

Date \_\_\_\_\_ Amount \$ \_\_\_\_\_  
 Description \_\_\_\_\_

Name of Benefit Recipient \_\_\_\_\_  
 Date \_\_\_\_\_ Description \_\_\_\_\_ Amount \$ \_\_\_\_\_

Name and Address of Payee/Vendor  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

If benefit was reimbursed, please report the date, the description, and the amount of the reimbursement.

Date \_\_\_\_\_ Amount \$ \_\_\_\_\_  
 Description \_\_\_\_\_

**CERTIFICATION**

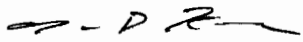
This certification shall be signed by a Governmental Affairs Agent employed by the Represented Entity or a responsible Financial or Governmental Affairs Officer of the Represented Entity.

I, Jason D. Kaune  
*(print name)*

hereby certify that I am duly authorized by

Merck Sharp & Dohme Corporation and its affiliates  
*(print name of Represented Entity)*

to file and certify the accuracy and correctness of this Annual Report of Lobbying Activity for calendar year 2010 .  
I certify that the statements made herein are true and accurate. I am aware that if any of the foregoing statements are willfully false, I may be subject to punishment.

  
\_\_\_\_\_  
Signature

3/3/2010  
\_\_\_\_\_  
Date