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Revised December 2011

U.S. Department of Justice
Civil Division

Radiation Exposure Compensation Program
Onsite Participant Claim Form

Claim form for cases filed under the Radiation Exposure Compensation Act.

General Instructions:
Read the entire claim form and complete all necessary parts. Failure to submit the required documentation will delay the processing of your claim. There are five claimant categories under the Act: uranium miner, miller, ore transporter, downwinder, and onsite participant. If you have any questions, call 1-800-729-7327 or visit our website at www.justice.gov/civil/common/reca.html. No individual may receive more than one payment under the Act. Sec. 7(b).

Part 1: YOU, the person filling out this form.

First name

Middle name

Last name

Maiden name, if applicable

Other names

Former names

Social Security number ___ - ___ - ____

Date of Birth (mm/dd/yy)

Mailing address

City

State

Zip Code

Phone number (day) ___ - ___ - ____

Phone number (evening) ___ - ___ - ____

Residence address

If you are a member of an Indian Tribe, please check the relevant box below.

☐ Apache ☐ Hopi

☐ Navajo ☐ Other _____

Print your census number here: _____

If you are a member of an Indian Tribe, complete page 18.

Have you received assistance from any of the following organizations?

☐ Office of Navajo Uranium Workers - Shiprock Office

☐ Office of Navajo Uranium Workers - Tuba City Office

☐ Other _____

Part 2: THE CLAIMANT, the person who became ill with a compensable disease. If YOU are the person who became ill you may proceed to Part 3 and are NOT required to fill out Part 2.

First name

Middle name

Last name

Maiden name, if applicable

Other names

Former names

Social Security number - -

Date of Birth (mm/dd/yy)

Date of Death(mm/dd/yy)

Part 3: RELATIONSHIP TO THE PERSON WHO BECAME ILL.

Please indicate your relationship to the person who became ill and on whose behalf you are filing below and follow the appropriate directions:

□ **Self** (go to Part 4 on page 3)

□ **Spouse** (go to Part 5 on page 3)

□ **Child** (go to Part 6 on page 4)

□ **Parent** (go to Part 7 on page 6)

□ **Grandchild** (go to Part 7 on page 6)

□ **Grandparent** (go to Part 7 on page 6)

Part 4: SELF-FILERS, individuals who became ill and are filing for themselves.

A SELF-FILER must submit the following certified or original documents:
To process this claim you will need to provide *certified or original* copies of the information requested in this claim form (photocopies, even if notarized, are not sufficient unless certified by the issuing institution). All original documents will be returned when this claim is resolved.

☐ Birth certificate: yours.

☐ Marriage certificate(s): documenting *any and all* changes of name, if applicable.

• If you are a SELF-FILER please continue to Part 8 of the claim form. You should NOT fill out Parts 5, 6, and 7.

Part 5: SURVIVING SPOUSE, the individual who was married to the person who became ill for at least one year prior to his or her death.

Please answer the following questions:

Is the person identified in Part 2 deceased? If "NO", you are not eligible to file this claim.

YES [ ] NO [ ]

Were you married to the claimant, the person who became ill, for at least one year immediately prior to his or her death? If "NO", you are not eligible to file this claim.

YES [ ] NO [ ]

Was the person who became ill married to anyone else BEFORE he or she married you?

YES [ ] NO [ ]

If yes, please list the name of each previous spouse and the dates that the marriage began and ended.

_____

_____

Have you ever been married to anyone else other than the person who became ill?

YES [ ] NO [ ]

If yes, please list the name of each spouse and the dates that the marriage began and ended.

_____
_____
_____
_____

A SPOUSE must submit the following certified or original documents:

To process this claim you will need to provide *certified or original* copies of the information requested in this claim form (photocopies, even if notarized, are not sufficient unless certified by the issuing institution). All original documents will be returned when this claim is resolved.

☐ Birth certificate: of the person who became ill.

☐ Death certificate: of the person who became ill.

☐ Marriage certificate: documenting your marriage to the person who became ill.

☐ Marriage certificate(s): documenting any previous marriages of the person who became ill, if applicable.

☐ Divorce decree(s) or death certificate(s): documenting the end of any previous marriages of the person who became ill, if applicable.

☐ Birth certificate: yours.

☐ Marriage certificate(s): documenting all of your other marriages, if applicable.

☐ Divorce decree(s) or death certificate(s): documenting the end of any of your marriages previous to your marriage to the claimant.

- **If you are a SPOUSE please continue to Part 8 of the claim form. You should NOT fill out Parts 4, 6, or 7.**

Part 6: SURVIVING CHILD, an individual who was a natural, adopted, or step-child of the person who became ill.

Please answer the following questions:
Is the person identified in Part 2 (the person who became ill) deceased? If "NO", you are not eligible to file this claim.

YES [ ] NO [ ]

Was the person who became ill ever married?

YES [ ] NO [ ]

If YES, list the name of each spouse, the date and place each marriage began, and the date and place of divorce or death of each spouse of the person who became ill.

_____
_____
_____
_____

Are you a natural child, adopted child, or step-child of the decedent?

NATURAL [ ] ADOPTED CHILD [ ] STEP-CHILD [ ]

Did the decedent have any other natural, adopted, or step-children? **YES [ ] NO [ ]**
If so, list the name of each child, date and place of birth, phone number, and current address or date and place of death.

1) Name: _____ Date and place of birth: _____
Date and place of death, if applicable:_____
Current address, if applicable:_____
Phone number, if applicable: _____
2) Name: _____ Date and place of birth: _____
Date and place of death, if applicable:_____
Current address, if applicable:_____
Phone number, if applicable: _____
3) Name: _____ Date and place of birth: _____
Date and place of death, if applicable:_____
Current address, if applicable:_____
Phone number, if applicable: _____

If there are more children of the claimant please use the back of this page or attach another sheet to provide the information requested above and check here: ☐

A SURVIVING CHILD must submit the following certified or original documents:

To process this claim you will need to provide *certified or original* copies of the information requested in this claim form (photocopies, even if notarized, are not sufficient unless certified by the issuing institution). All original documents will be returned when this claim is resolved.

☐ Birth certificate: of the person who became ill.

☐ Death certificate: of the person who became ill.

☐ Marriage certificate(s): of the person who became ill.

☐ Divorce decree(s) or death certificate(s): documenting that any and all marriages of the person who became ill have ended.

☐ Birth certificate or papers of adoption: yours.

☐ Marriage certificate(s): documenting any and all of your name changes, if applicable.

☐ If you are a step-child of the person who became ill, send proof that their spouse was one of your

natural parents and any records which show that you lived with the person who became ill in a regular parent-child relationship (for example, school records).

☐ Death certificates: of any siblings that have passed away.

In addition, the Radiation Program will need identification documents for **ALL** other eligible surviving children of the person who became ill including:
☐ Birth certificate for each eligible surviving beneficiary
☐ Marriage certificate(s) for each eligible surviving beneficiary, only when a change of name has occurred.
☐ **If you would like to expedite your claim, have each eligible surviving beneficiary review the claim and sign their name on page 19.**

- **If you are a SURVIVING CHILD please continue to Part 8 of the claim form. You should NOT fill out Parts 4, 5, or 7.**

Part 7: PARENTS, GRANDCHILDREN or GRANDPARENTS

If you are filing as a PARENT, a GRANDCHILD, or a GRANDPARENT of the person who became ill, a member of the Radiation Program staff will contact you to provide further assistance in establishing your relationship to the person who became ill with the compensable disease.

What is your relationship to the person who became ill?

PARENT [ ] GRANDCHILD [ ] GRANDPARENT [ ]

***At this time*, you will need to submit the following certified or original documents:**

To process this claim you will need to provide *certified or original* copies of the information requested in this claim form (photocopies, even if notarized, are not sufficient unless certified by the issuing institution). All original documents will be returned when this claim is resolved.

☐ Birth certificate: of the person who became ill.

☐ Death certificate: of the person who became ill.

☐ Marriage certificate(s): of the person who became ill, if applicable.

☐ Divorce decree(s) or death certificate(s): documenting the end of any marriages of the person who became ill, if applicable.

☐ Birth certificate: yours.

☐ Marriage certificate(s): documenting any and all of your name changes.

Part 8: ONSITE PARTICIPATION.

The information provided by you in this section aids the Radiation Program in establishing the onsite participation of the person who became ill. **Please include any and all information you have regarding the onsite participation of the person who became ill. Even incomplete information may be helpful in establishing onsite participation.**

[ ] Please include the DD-214 (Report of Separation) or Honorable Discharge record of the person who became ill, if applicable and available.

Please check the site where participation occurred and provide the dates of participation. If participation did not occur at one of the following sites, you are not eligible to file this claim.

South Atlantic Test Site [ ]
Dates present:_____

Pacific Test Sites [ ]
Dates present:_____

Nevada Test Site [ ]
Dates present:_____

Trinity Test Site [ ]
Dates present:_____

Any designated location in a government installation where equipment used in an atmospheric detonation was decontaminated [ ]
Dates present:_____

Any designated location used for the purpose of monitoring fallout of an atmospheric nuclear test conducted at the Nevada Test Site [ ]
Dates present:_____

Note: If you are filing because the person who became ill was present at Hiroshima or Nagasaki, please understand that you are **NOT** eligible for compensation.

Please check one of the options below and follow the appropriate directions:

☐ If the person who became ill was employed by the Department of Defense or was a contractor of the Department of Defense, **please fill out the form on the next page and then skip to page 10**.

☐ If the person who became ill was employed by the Atomic Energy Commission, the Public Health Service, Civil Defense, or was a contractor of the Atomic Energy Commission, **please fill out page 9, then proceed to page 10. Do not fill out the form on the next page.**

FOR DEPARTMENT OF DEFENSE CONTRACTORS AND PERSONNEL

Please include any and all information you have regarding the onsite participation of the person who became ill. Even incomplete information may be helpful in establishing onsite participation.

Site Name: _____

Dates of assignment:_____

Description of Duties, Responsibilities, and Activities while Onsite: _____

_____

_____

_____

_____

_____

_____

☐ *Please use a separate sheet of paper and check here if additional space is needed.*

If civilian, name of agency or company:_____

_____

Military Identification Information:

Service Number:_____

Rank: _____

Branch of Service:_____

Unit: _____

.

FOR ATOMIC ENERGY COMMISSION (DEPARTMENT OF ENERGY) CONTRACTORS AND PERSONNEL, OR PUBLIC HEALTH SERVICE PERSONNEL, OR CIVIL DEFENSE PERSONNEL

Please include any and all information you have regarding the onsite participation of the person who became ill. Even incomplete information may be helpful in establishing onsite participation.

Name or other identifying information associated with the individual's employer, organization, or unit assignment at the time of the participation onsite:_____

_____

_____

Site Name: _____

Dates of assignment:_____

Description of Duties, Responsibilities, and Activities while Onsite: _____

_____

_____

_____

_____

_____

_____

☐ *Please use a separate sheet of paper and check here if additional space is needed*

Part 9: COMPENSABLE DISEASE.

Place a check next to the SPECIFIED COMPENSABLE DISEASE that the person who became ill developed. If you are not sure which disease the claimant contracted, you may check more than one box.

If the claimant did NOT become ill with one of the diseases listed below, he or she is not eligible for compensation.

☐ leukemia, but NOT chronic lymphocytic leukemia

☐ multiple myeloma

☐ primary cancer of the pharynx

☐ lymphoma, other than Hodgkin's disease

☐ primary cancer of the small intestine

☐ primary cancer of the salivary gland

☐ primary cancer of the brain

☐ primary cancer of the stomach

☐ primary cancer of the urinary bladder

☐ primary cancer of the colon

☐ primary cancer of the thyroid

☐ primary cancer of the pancreas

☐ primary cancer of the female breast

☐ primary cancer of the male breast

☐ primary cancer of the esophagus

☐ primary cancer of the bile ducts

☐ primary cancer of the liver (except if cirrhosis or hepatitis B is indicated)

☐ primary cancer of the gall bladder

☐ primary cancer of the lung

☐ primary cancer of the ovary

Please see Part 11 on page 12 for instructions on how to establish a diagnosis of a compensable disease.

Have you received assistance from a Radiation Exposure Screening and Education Program (RESEP) clinic?

YES [ ] NO [ ]

Please specify which clinic assisted you (if you do not know the name of the clinic, please state the location of the clinic):_____

Part 10: PREVIOUS PAYMENTS OF MONEY.

Please answer the following questions by checking the appropriate answer.
If you check "YES," please use a separate sheet of paper to identify the date, amount, and person or organization from whom EACH AND EVERY payment of money was received, and explain the circumstances surrounding the payments.

Have you or anyone else received any payment of money pursuant to final award or settlement on a claim (other than a claim for worker's compensation) against any person (or corporation), that is based on the illness for which this claim is submitted?

YES [ ] NO [ ]

Have you or anyone else received any payment made by the Department of Veterans Affairs that is based on the illness for which this claim is submitted? (Include disability payments made to the person who became ill, and Dependency and Indemnity Compensation payments made due to the death from illness for which this claim is submitted. Do NOT include retirement pensions, medical and dental benefits, education benefits, loans and other noncash benefits, vocational rehabilitation benefits, SGLI or VGLI or other life insurance benefits, or burial benefits.)

YES [ ] NO [ ]

Have you or anyone else filed a claim under the Department of Labor's Energy Employees Occupational Illness Compensation Program Act (EEOICPA)?

YES [ ] NO [ ]

PART 11: PROOF OF DISEASE. This section describes documents you may submit to establish that the person who became ill contracted a specified compensable disease.

Please choose one or both of the following methods to demonstrate that the claimant contracted a compensable disease.

☐ I HAVE SUBMITTED CERTIFIED MEDICAL RECORDS SHOWING A DIAGNOSIS OF A COMPENSABLE CANCER

In order for you to establish that the person who became ill contracted a compensable disease, you will need to submit certain medical documentation reflecting a diagnosis of cancer. Documentation that may be used to establish a diagnosis of a compensable disease includes, but is not limited to, the following:

- pathology report of tissue biopsy or surgical resection
- operative report
- hospital discharge summary report
- physician summary report
- death certificate, dated and signed by a physician
- autopsy report

For a complete list of the specific documents accepted for each illness, consult the medical records attachment at the end of this form.

To certify the record, ask the source of the record (hospital or doctor's office) to attach a cover letter to the record stating, "the attached medical records consisting of [# of] pages pertaining to [the person who became ill] are true and accurate copies of records kept in our files."

☐ I WANT THE RADIATION PROGRAM TO CONTACT ONE OF THE CANCER REGISTRIES LISTED BELOW AND I HAVE SIGNED THE AUTHORIZATION TO RELEASE MEDICAL INFORMATION.

Some states have cancer registries which maintain records of individuals who have had cancer diagnosed in that state. For your convenience, the Radiation Program has made arrangements with the following six states that have such registries. *If the person who became ill with a specified compensable disease was diagnosed with that disease in any of the following states and you wish to have the Radiation Program contact that state's registry to confirm a diagnosis of cancer, please mark the box next to the appropriate state. You will also need to complete and sign the medical release on page 16.*

☐ Arizona	☐ New Mexico
☐ Colorado	☐ Utah
☐ Nevada	☐ Wyoming

Part 12: ATTORNEY REPRESENTATION.

Have you hired an attorney to represent you for the purpose of filing this claim?

YES [ ] NO [ ]

PLEASE NOTE: **You are not required to hire an attorney to file this claim.** If you wish to be represented by an attorney, you are responsible for making arrangements for that attorney to be paid. Under the Act, notwithstanding any contract, an attorney may not receive more than 2 percent for the filing of an initial claim; and 10 percent with respect to any claim in which a representative has made a contract for services before July 10, 2000; or a resubmission of a denied claim. Attorneys are permitted to recover costs and expenses regardless of whether the claim is approved or denied. Attorneys representing claimants are required to submit a signed representation agreement, retainer agreement, fee agreement, or contract documenting the attorney's authorization to represent the claimant or beneficiary. The document must acknowledge that the Act's fee limitations are satisfied. The attorney must also submit an annual statement of active membership and good standing of the bar of the highest court of a state, as provided in the regulations.

If you choose to hire an attorney, the Radiation Program will correspond and communicate only with your attorney on all matters related to your claim.

If "YES," please indicate your attorney's name, firm, address and phone number here:

First name **Middle name**

Last name

Firm

Mailing address

City **State** **Zip Code**

Phone number (day) **Fax number**

Part 13: ATTORNEY ACKNOWLEDGMENT.

I acknowledge that I have been retained by the claimant or beneficiary(ies) in this matter. I understand that only in the event of a successful outcome am I, along with any assistants or experts retained by me on behalf of the claimant or beneficiary(ies), entitled to receive the statutory fee in connection with a claim filed under the Radiation Exposure Compensation Act. I am permitted to recover costs and expenses regardless of whether the claim is approved or denied. I understand that I am entitled to receive the following:

[ ] 2% for the filing of an initial claim.

[ ] 10% with respect to any claim in which a representative has made a contract for services before July 10, 2000; or a resubmission of a denied claim.

x_____

Signature of Attorney representing claimant or beneficiary **Date**

Part 14: COURT APPOINTED LEGAL GUARDIANS.

PLEASE NOTE: A person who has power of attorney is NOT a legal guardian of that person. If you are a legal guardian, please submit certified or original court documentation showing power of guardianship over the person filing this claim.

First name of legal guardian

Middle name

Last name

Mailing address

City

State

Zip Code

Phone number (day) - -

Phone number (evening) - -

Part 15: **SIGNATURE.** We cannot process this claim form if you do not sign this page.

I declare under penalty of perjury that the information in this claim is true, correct, and complete to the best of my knowledge and belief.

X_____

Signature of person identified in Part 1 or Legal Guardian identified in Part 14 **Date**

Civil Penalty for Presenting a Fraudulent Claim or Making False Statements or Using False Records

The declarant shall forfeit and pay to the United States the sum of $10,000 plus treble the amount of damages sustained by the United States. (See 31 U.S.C. Section 3729).

Criminal Penalty for Presenting a Fraudulent Claim or Making False Statements

Fine and imprisonment for not more than 5 years. (See 18 U.S.C. Sections 287 and 1001).

You may file this form by mailing it to:

Radiation Exposure Compensation Program
U.S. Department of Justice
P.O. Box 146
Ben Franklin Station
Washington, DC 20044-0146

Privacy Act

The authority for the collection of this information is the Radiation Exposure Compensation Act of 1990, 42 U.S.C. § 2210 note (2006). The information you provide will be used to verify your identity, to verify your eligibility, and to verify any previous payments made in connection with the compensable disease you identified in Part 11 of the claim form. Some or all of the information you provide may be released to federal, state, and local government agencies or private organization for the purpose of confirming your identity, your eligibility, and any previous payments made in connection with the compensable disease. The information may also be released when otherwise authorized by statute or regulation. Disclosure of the information by you is voluntary; however, it may not be possible to process your claim without the information.

Reporting Burden

Public Reporting burden for this collection of information is estimated to average 2.5 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining that data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection of information, including suggestions for reducing this burden to: Radiation Exposure Compensation Program, U.S. Department of Justice, P.O. Box 146, Ben Franklin Station, Washington, DC 20044-0146.

U.S. Department of Justice
Civil Division

AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION

To: Arizona Tumor Registry
Colorado Cancer Registry
Wyoming Tumor Registry
New Mexico Tumor Registry
Nevada Statewide Cancer Registry
Utah Cancer Registry

I hereby authorize the release of any and all medical and other information in your possession, custody, and control to representatives of the Radiation Exposure Compensation Program (RECP), Department of Justice, relating to the individual whose name appears on line 1 of this form. This data is required to determine eligibility for compensation under the Radiation Exposure Compensation Act, 42 U.S.C. § 2210 note (2006).

For the RECP to request medical information on your behalf, you must **SIGN THIS FORM.**

1. Name of the individual whose records are to be released (First, Middle, Maiden, Last, Other).

_____

2. Social Security number of the individual whose records are to be released.

_____

3. Birth date of the individual whose records are to be released.

_____

4. Date of death of individual whose records are to be released. _____

5. Name of the individual requesting release of information (if different from the individual listed on line 1).

_____

6. Relationship to the individual listed on line 1.

_____

X_____ _____
Signature Date

Return this authorization with the claim form to:

Radiation Exposure Compensation Program
U. S. Department of Justice
P.O. Box 146
Ben Franklin Station
Washington, D.C. 20044-0146

U.S. Department of Justice

Certification of Identity and Privacy Act Release

RADIATION EXPOSURE COMPENSATION PROGRAM
CLAIM NO. 201-16-_____

Privacy Act Statement. The purpose of this request is to ensure that records of individuals that are maintained by the Radiation Exposure Compensation Program of the U.S. Department of Justice are not wrongfully disseminated. In accordance with 28 CFR Section 16.41(d) personal data sufficient to identify the individuals submitting requests for information under the Privacy Act of 1974, 5 U.S.C. Section 552a, is required. False information on this form may subject the requester to criminal penalties under 18 U.S.C. Section 1001 and/or 5 U.S.C. Section 552a(i)(3).

Section 1: Certification of Identity. Please certify your identity. (The individual filing this claim.)

Full Name_____

Citizenship Status[1]_____Social Security Number[2]_____

Current Address_____

Date of Birth _____ Place of Birth _____

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. Section 1001 by a fine of not more than $10,000 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. 552a(i)(3) by a fine of not more than $5,000.

Signature of individual filing claim_____ Date_____

Section 2: Authorization to Release Information to Another Person (OPTIONAL)

If you would like the Radiation Program staff to speak to provide information to someone other than yourself about your claim, you must complete the section below.

Pursuant to 5 U.S.C. Section 552a(b), I authorize the U.S. Department of Justice to release any and all information relating to my claim to:

Print or Type Name _____ Relationship to Requester_____

Phone Number _____ Current Address _____

Signature of individual authorizing this release_____ Date_____

[1]Individuals submitting a request under the Privacy Act of 1974 must be either "a citizen of the United States or an alien lawfully admitted for permanent residence," pursuant to 5 U.S.C. Section 552a(a)(2). Requests will be processed as Freedom of Information Act requests pursuant to 5 U.S.C. Section 552, rather than Privacy Act requests, for individuals who are not United States citizens or aliens lawfully admitted for permanent residence.

[2]Providing your social security number is voluntary. You are asked to provide your social security number only to facilitate the identification of records relating to you. Without your social security number, the Department may be unable to locate any or all records pertaining to you.

RELEASE OF TRIBAL VITAL RECORDS

Please check the applicable box so that we may verify information through the tribe of which you are a member:

TO: THE NAVAJO NATION OFFICE OF VITAL RECORDS ☐
THE HOPI TRIBE ENROLLMENT DEPARTMENT ☐
SAN CARLOS APACHE TRIBAL ENROLLMENT OFFICE ☐
_____ ☐
Other Tribal Records Office

RE: AUTHORIZATION TO RELEASE INFORMATION

Claimant name (Please print)**:**_____

I hereby authorize the release of vital statistics information and/or records held by the _____ (name of tribal organization) to a representative of the Radiation Exposure Compensation Program of the United States Department of Justice pursuant to 5 U.S.C. § 552a(b). This information is required to determine eligibility for compensation under the Radiation Exposure Compensation Act, 42 U.S.C. § 2210 note (2006).

X_____
Signature, thumbprint or mark

_____
Date

SIGNATURES OF ELIGIBLE SURVIVING BENEFICIARIES

If you are filing as a surviving child, you may expedite your claim by having each of your siblings review the claim and sign their name below. It is **NOT** necessary to have all surviving beneficiaries fill out this page, but the Radiation Program will have to individually contact all eligible surviving beneficiaries who do not sign this page. Fill out this page **ONLY** if you are a **surviving child** of the person who became ill with a compensable disease. If you are a legal guardian signing on behalf of a surviving child, please indicate your status below.

By signing this page, you declare under penalty of perjury that the information in this claim is true, correct, and complete to the best of your knowledge and belief.

1. Name of Eligible Surviving Beneficiary (Please print):_____
Social Security number: _____Date:_____
Signature of Eligible Surviving Beneficiary:_____
If represented by an attorney, please print his or her name here: _____
Phone number: _____

2. Name of Eligible Surviving Beneficiary (Please print):_____
Social Security number: _____Date:_____
Signature of Eligible Surviving Beneficiary:_____
If represented by an attorney, please print his or her name here: _____
Phone number: _____

3. Name of Eligible Surviving Beneficiary (Please print):_____
Social Security number: _____Date:_____
Signature of Eligible Surviving Beneficiary:_____
If represented by an attorney, please print his or her name here: _____
Phone number: _____

4. Name of Eligible Surviving Beneficiary (Please print):_____
Social Security number: _____Date:_____
Signature of Eligible Surviving Beneficiary:_____
If represented by an attorney, please print his or her name here: _____
Phone number: _____

☐ *If there are other children filing on behalf of the claimant, please use the back of this page or attach another sheet with the information requested above and their* ***signature*** *and check here.*

Civil Penalty for Presenting a Fraudulent Claim or Making False Statements or Using False Records

The declarant shall forfeit and pay to the United States the sum of $10,000 plus treble the amount of damages sustained by the United States. (See 31 U.S.C. Section 3729).

Criminal Penalty for Presenting a Fraudulent Claim or Making False Statements

Fine and imprisonment for not more than 5 years. (See 18 U.S.C. Sections 287 and 1001).

Privacy Act

The authority for the collection of this information is the Radiation Exposure Compensation Act of 1990, 42 U.S.C. § 2210 note (2006). The information you provide will be used to verify your identity, to verify your eligibility, and to verify any previous payments made in connection with the compensable disease you identified in Part 9 of the claim form. Some or all of the information you provide may be released to federal, state, and local government agencies or private organization for the purpose of confirming your identity, your eligibility, and any previous payments made in connection with the compensable disease. The information may also be released when otherwise authorized by statute or regulation. Disclosure of the information by you is voluntary; however, it may not be possible to process your claim without the information.

MEDICAL RECORDS ATTACHMENT

Listed below are the specified compensable diseases and the records which we will accept as proof that the person who became ill had a specified compensable disease.

Tear off this attachment and take it to a doctor or hospital in possession of the records of the person who became ill with one of the specified compensable diseases.

Show this list to the doctor or hospital and ask them to give you original or certified copies of one or more of the records listed below. Select the record(s) containing a diagnosis of the disease, if possible. Otherwise, send the records listed below that are available. If you have questions, call the Radiation Program at 1-800-729-7327.

(1) **Multiple myeloma**.
- (i) Pathology report of tissue biopsy;
- (ii) Autopsy report;
- (iii) Report of serum electrophoresis;
- (iv) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Hematology summary or consultation report;
  - (D) Medical oncology summary or consultation report;
  - (E) X-ray report;
- (v) Death certificate, provided that it is signed by a physician at the time of death.

(2) **Lymphoma, other than Hodgkin's disease**.
- (i) Pathology report of tissue biopsy;
- (ii) Autopsy report;
- (iii) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Hematology consultation or summary report;
  - (D) Medical oncology consultation or summary report;
- (iv) Death certificate, provided that it is signed by a physician at the time of death.

3) **Primary cancer of the thyroid**.
- (i) Pathology report of tissue biopsy or fine needle aspirate;
- (ii) Autopsy report;
- (iii) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary;
  - (C) Operative summary report;
  - (D) Medical oncology summary or consultation report;
- (iv) Death certificate, provided that it is signed by a physician at the time of death.

(4) **Primary cancer of the male or female breast**.
- (i) Pathology report of tissue biopsy or surgical resection;
- (ii) Autopsy report;
- (iii) One of the following summary medical reports:
  - (A) Physician summary report;

(B) Hospital discharge summary;
(C) Operative report;
(D) Medical oncology summary or consultation report;
(E) Radiotherapy summary or consultation report;
(iv) Report of mammogram;
(v) Report of bone scan;
(vi) Death certificate, provided that it is signed by a physician at the time of death.

(5) **Primary cancer of the esophagus**.
(i) Pathology report of tissue biopsy or surgical resection;
(ii) Autopsy report;
(iii) Endoscopy report;
(iv) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Operative report;
(D) Radiotherapy report;
(E) Medical oncology consultation or summary report;
(v) One of the following radiological studies:
(A) Esophagram;
(B) Barium swallow;
(C) Upper gastrointestinal (GI) series;
(D) Computerized tomography (CT) scan;
(E) Magnetic resonance imaging (MRI);
(vi) Death certificate, provided that it is signed by a physician at the time of death.

(6) **Primary cancer of the stomach**.
(i) Pathology report of tissue biopsy or surgical resection;
(ii) Autopsy report;
(iii) Endoscopy or gastroscopy report;
(iv) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Operative report;
(D) Radiotherapy report;
(E) Medical oncology summary report;
(v) One of the following radiological studies:
(A) Barium swallow;
(B) Upper gastrointestinal (GI) series;
(C) Computerized tomography (CT) series;
(D) Magnetic resonance imaging (MRI);
(vi) Death certificate, provided that it is signed by a physician at the time of death.

(7) **Primary cancer of the pharynx**.
(i) Pathology report of tissue biopsy or surgical resection;
(ii) Autopsy report;
(iii) Endoscopy report;
(iv) One of the following summary medical reports:
(A) Physician summary;
(B) Hospital discharge summary;
(C) Report of otolaryngology examination;

(D) Radiotherapy summary report;
(E) Medical oncology summary report;
(F) Operative report;

(v) Report of one of the following radiological studies:
(A) Laryngograms;
(B) Tomograms of soft tissue and lateral radiographs;
(C) Computerized tomography (CT) scan;
(D) Magnetic resonance imaging (MRI);

(vi) Death certificate, provided that it is signed by a physician at the time of death.

(8) **Primary cancer of the small intestine**.

(i) Pathology report of tissue biopsy;
(ii) Autopsy report;
(iii) Endoscopy report, provided the examination covered the duodenum and parts of the jejunum;
(iv) Colonoscopy report, providing the examination covered the distal ileum;
(v) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary;
(C) Report of gastroenterology examination;
(D) Operative report;
(E) Radiotherapy summary report;
(F) Medical oncology summary or consultation report;
(vi) Report of one of the following radiologic studies:
(A) Upper gastrointestinal (GI) series with small bowel follow-through;
(B) Angiography;
(C) Computerized tomography (CT) scan;
(D) Magnetic resonance imaging (MRI);
(vii) Death certificate, provided that it is signed by a physician at the time of death.

(9) **Primary cancer of the pancreas**.

(i) Pathology report of tissue biopsy or fine needle aspirate;
(ii) Autopsy report;
(iii) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Radiotherapy summary report;
(D) Medical oncology summary report;
(iv) Report of one of the following radiographic studies:
(A) Endoscopic retrograde cholangiopancreatography (ERCP);
(B) Upper gastrointestinal (GI) series;
(C) Arteriography of the pancreas;
(D) Ultrasonography;
(E) Computerized tomography (CT) scan;
(F) Magnetic resonance imaging (MRI);
(v) Death certificate, provided that it is signed by a physician at the time of death.

(10) **Primary cancer of the bile ducts**.

(i) Pathology of tissue biopsy or surgical resection;
(ii) Autopsy report;
(iii) One of the following summary medical reports:
(A) Physician summary report;

(B) Hospital discharge summary report;
(C) Operative report;
(D) Gastroenterology consultation report;
(E) Medical oncology summary or consultation report;

(iv) Report of one of the following radiographic studies:
(A) Ultrasonography;
(B) Endoscopic retrograde cholangiography;
(C) Percutaneous cholangiography;
(D) Computerized tomography (CT) scan;

(v) Death certificate, provided that it is signed by a physician at the time of death.

(11) **Primary cancer of the gall bladder**.

(i) Pathology report of tissue from surgical resection;
(ii) Autopsy report;
(iii) Report of one of the following radiological studies:
(A) Computerized tomography (CT) scan;
(B) Magnetic resonance imaging (MRI);
(C) Ultrasonography (ultrasound);

(iv) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Operative report;
(D) Radiotherapy report;
(E) Medical oncology summary or report;

(v) Death certificate, provided that it is signed by a physician at the time of death.

(12) **Primary cancer of the liver**.

(i) Pathology report of tissue biopsy or surgical resection;
(ii) Autopsy report;
(iii) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Medical oncology summary report;
(D) Operative report;
(E) Gastroenterology report;

(iv) Report of one of the following radiological studies:
(A) Computerized tomography (CT) scan;
(B) Magnetic resonance imaging (MRI);

(v) Death certificate, provided that it is signed by a physician at the time of death.

(13) **Primary cancer of the lung**.

(i) Pathology report of tissue biopsy or resection, including, but not limited to specimens obtained by any of the following methods:
(A) Surgical resection;
(B) Endoscopic endobronchial or transbronchial biopsy;
(C) Bronchial brushings and washings;
(D) Pleural fluid cytology;
(E) Fine needle aspirate;
(F) Pleural biopsy;
(G) Sputum cytology;

(ii) Autopsy report;
(iii) Report of bronchoscopy, with or without biopsy;

(iv) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Radiotherapy summary report;
(D) Medical oncology summary report;
(E) Operative report;
(v) Report of one of the following radiology examinations:
(A) Computerized tomography (CT) scan;
(B) Magnetic resonance imaging (MRI);
(C) X-rays of the chest;
(D) Chest tomograms;
(vi) Death certificate, provided that it is signed by a physician at the time of death.

(14) **Primary cancer of the salivary gland**.
(i) Pathology report of tissue biopsy or resection;
(ii) Autopsy report;
(iii) Report of otolaryngology or oral maxillofacial examination;
(iv) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Radiotherapy summary report;
(D) Medical oncology summary report;
(E) Operative report;
(v) Report of one of the following radiology examinations:
(A) Computerized tomography (CT) scan;
(B) Magnetic resonance imaging (MRI);
(vi) Death certificate, provided that it is signed by a physician at the time of death.

(15) **Primary cancer of the urinary bladder**.
(i) Pathology report of tissue biopsy or resection;
(ii) Autopsy report;
(iii) Report of cytoscopy, with or without biopsy;
(iv) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Radiotherapy summary report;
(D) Medical oncology summary report;
(E) Operative report;
(v) Report of one of the following radiology examinations:
(A) Computerized tomography (CT) scan;
(B) Magnetic resonance imaging (MRI);
(vi) Death certificate, provided that it is signed by a physician at the time of death.

(16) **Primary cancer of the brain**.
(i) Pathology report of tissue biopsy or resection;
(ii) Autopsy report;
(iii) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Radiotherapy summary report;
(D) Medical oncology summary report;
(E) Operative report;
(iv) Report of one of the following radiology examinations:

(A) Computerized tomography (CT) scan;
(B) Magnetic resonance imaging (MRI);
(C) CT or MRI with enhancement

(v) Death certificate, provided that it is signed by a physician at the time of death.

(17) **Primary cancer of the colon**.

(i) Pathology report of tissue biopsy;
(ii) Autopsy report;
(iii) Endoscopy report, provided the examination covered the duodenum and parts of the jejunum;
(iv) Colonoscopy report, providing the examination covered the distal ileum;
(v) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary;
(C) Report of gastroenterology examination;
(D) Operative report;
(E) Radiotherapy summary report;
(F) Medical oncology summary or consultation report;
(vi) Report of one of the following radiologic studies:
(A) Upper gastrointestinal (GI) series with small bowel follow-through;
(B) Angiography;
(C) Computerized tomography (CT) scan;
(D) Magnetic resonance imaging (MRI);
(vii) Death certificate, provided that it is signed by a physician at the time of death.

(18) **Primary cancer of the ovary**.

(i) Pathology report of tissue biopsy or resection;
(ii) Autopsy report;
(iii) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Radiotherapy summary report;
(D) Medical oncology summary report;
(E) Operative report;
(iv) Death certificate, provided that it is signed by a physician at the time of death.

(19) **Leukemia, but NOT chronic lymphocytic leukemia**

(i) Bone marrow biopsy or aspirate report;
(ii) Peripheral white blood cell differential count report;
(iii) Autopsy report;
(iv) Hospital discharge summary;
(v) Physician summary;
(vi) History and physical report;
(vii) Death certificate, provided that it is signed by a physician at the time of death.