OMB No. 0915-0282
Expiration date: 05-31-2004

SMALLPOX VACCINE INJURY COMPENSATION PROGRAM

CERTIFICATION FORM

MEMBERSHIP IN, AND RECEIPT OF THE SMALLPOX VACCINE UNDER, AN APPROVED SMALLPOX EMERGENCY RESPONSE PLAN

The certification is subject to audit by the U.S. Department of Health and Human Services' Office of Inspector General, the U.S. Department of Justice, the U.S. Department of Labor, and/or the General Accounting Office.

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0282. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33 Rockville, Maryland, 20857.

1. INFORMATION ABOUT THE INDIVIDUAL WHO RECEIVED THE SMALLPOX VACCINATION

The individual is or was a member of, and received the smallpox vaccine under, a U.S. Department of Health and Human Services (HHS), State, or local smallpox emergency response plan (a Plan).

Name: _____Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of smallpox vaccination administered under a Plan: _____

Check the box that best describes the emergency response role of the individual who was vaccinated:
[ ] health care worker [ ] firefighter [ ] emergency medical worker
[ ] law enforcement officer [ ] security-related worked [ ] public safety worker
[ ] support worker for above persons (please specify)_____

2. CERTIFYING ENTITY INFORMATION

This section is to be completed by an authorized representative of an entity that administered the smallpox vaccine to the individual described above under a Plan.

Name of Representative: _____

Name of entity: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Telephone number: _____

This entity participated in the administration of the smallpox vaccine through an HHS-approved smallpox emergency response plan and is best described as (check one):
[ ] The U.S. Department of Health and Human Services [ ] State government
[ ] Local government [ ] Private health care entity

Name of the HHS-approved smallpox emergency response plan in which the individual described in Section 1 is/was a participant: _____

I have reviewed all of the information entered on this form for accuracy, and certify that the information is true, complete, and accurate to the best of my knowledge. I understand that if I knowingly and willingly made any misrepresentation or false

statement in this information, I may be subject to prosecution (a fine and/or imprisonment for up to 5 years) under Section 1001 of the United Stated Criminal Code (18 U.S.C. § 1001).

Signature of Individual signing on behalf of the entity	Title	Date

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payment. The information collected will be maintained confidentially pursuant to the Privacy Act.