SMALLPOX VACCINE INJURY COMPENSATION PROGRAM

CERTIFICATION FORM INSTRUCTIONS

This form is to be used to identify individuals who are members of a U.S. Department of Health and Human Services (HHS)-approved smallpox emergency response Plan (a Plan) who received a smallpox vaccination under that Plan. It is to be used by smallpox vaccine recipients, vaccinia contacts, survivors of smallpox vaccine recipients or vaccinia contacts, their estates, or personal representatives of anyone requesting benefits under the Smallpox Vaccine Injury Compensation (SVIC) Program to certify that the smallpox vaccine recipient met certain eligibility criteria of the Smallpox Emergency Personnel Protection Act of 2003.

Include the Certification Form in your Request Package.

CHANGES IN INFORMATION PROVIDED

For changes in the information provided in this Certification Form, notify in writing the SVIC Program Office as soon as possible at 5600 Fishers Lane, Room 16C-17, Rockville, MD 20857.

FILLING OUT THE CERTIFICATION FORM

Please type or print clearly all information requested.

SECTION 1 Instructions

This section describes the individual who is/was a member of a Plan and who received a smallpox vaccination under that Plan.

Name: The full name of the individual who received the smallpox vaccine.
Social Security Number: That individual's 9-digit Social Security number, if known.
Address: That individual's current home address.
City: That individual's current city of residence.
State: That individual's current state of residence.
Zip Code: The 5 or 9 digit zip code for that individual's current residence.
Date of Smallpox Vaccination administered under the response plan: The date the individual received a smallpox vaccination as part of a Plan.
Check the box that best describes the emergency response role of the individual who was vaccinated: The Act lists the job categories for individuals in smallpox emergency response plans. Check the one category that best describes the individual who received the smallpox vaccination. If the individual is a support worker for any of the named categories, check that box and write in the type of support work (e.g., janitor).

SECTION 2 Instructions

This section describes the Smallpox Emergency Response Plan entity and the certifier on its behalf.

Name of Representative: The name of the individual who represents the entity that administered the smallpox vaccine under an HHS-approved smallpox emergency response plan.

Name of entity: The name of the certifying entity (e.g., a hospital, a fire department, a county health department, etc.)

Address: The entity's business address.

City: The entity's city.

State: The entity's state.

Zip Code: The entity's 5 or 9 digit zip code.

Telephone Number: The certifier's daytime telephone number, including the area code, and extension.

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): Check the box that best describes the entity (e.g., the U.S. Department of Health and Human Services, State government, local government, Private health care entity). If other, please describe.

Smallpox emergency response plan in which he or she was/is a member: The individual's plan (e.g., the State of Minnesota's smallpox emergency response plan)

Signature of the individual signing on behalf of the entity: to be signed by the certifier, not the individual who received the vaccine, certifying that the individual who received the smallpox vaccine is/was a member of, and received the smallpox vaccine under, a Plan.

Title: The job title of the certifier.

Date: The date the certifier signed the Certification Form.

By signing Section 2, the certifier is attesting under penalty of prosecution that all statements in the Certification Form are true and accurate to the best of his or her knowledge.