OMB Approval No. 0000-0000
Revised

U.S. Department of Justice
Civil Division

Radiation Exposure Compensation Program
Uranium Mill Employee 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.usdoj.gov/civil/torts/const/reca. 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 ☐ Acoma ☐ Hopi
☐ Navajo ☐ Laguna ☐ Other _____

Print your census number here: _____
If you are a member of an Indian Tribe, fill out page 17.

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 lung cancer, a nonmalignant respiratory disease, renal cancer, or chronic renal 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 decedent, send proof that the decedent's spouse was one of your natural parents and any records which show that you lived with the decedent 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 form and sign their name on page 18.**

• **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: **EMPLOYMENT HISTORY**. Provide the history of the claimant's employment in a uranium mill (including employment in the milling operations involving the processing of uranium ore or vanadium-uranium ore) for a period of at least one (1) year during the period beginning on January 1, 1942, and ending on December 31, 1971. Please follow the directions below.

Was the person who became ill employed in any other kind of work in the uranium industry between 1942 and 1971 besides milling?

YES [ ] NO [ ]

If so, please describe.

_____

_____

Did the person who became ill participate in any of the following studies? (Please check any that apply):

☐ Public Health Service Study of Uranium Miners/National Institute for Occupational Safety and Health

☐ St. Mary's Hospital Study of Uranium Miners

☐ University of Mew Mexico School of Medicine/Tumor Registry Study of Uranium Miners

Next, please follow the directions below.

☐ Fill in the chart on the next page with as much work history information as possible concerning the person who became ill. Begin with the earliest period of employment and continue chronologically until the last period of employment.

☐ Provide any records you can which show that the claimant worked in the uranium mills listed on the chart. Send original or certified copies, if possible. If you cannot obtain original or certified copies, send the records you have and a short note explaining why you cannot obtain original or certified copies.

Name of Employer	Name of Mill	County and State	Dates Worked (Month/Year-Month/ Year)	Occupation or Activity in Mill	Identify and Attach Records Reflecting Each Period of Employment

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, you are not eligible for compensation.

☐ lung cancer (including any physiological condition of the lung, trachea, or bronchus that is recognized as "lung cancer")

☐ pulmonary fibrosis, fibrosis of the lung

☐ renal cancer

☐ silicosis

☐ cor pulmonale related to fibrosis of the lung

☐ pneumoconiosis

☐ chronic renal disease (including nephritis and kidney tubal tissue injury)

Part 10: PROOF OF COMPENSABLE DISEASE. This part concerns records which can prove that the person identified in Part 2 became ill with lung cancer or a nonmalignant respiratory disease. Please choose one or more of the following methods to establish a diagnosis of lung cancer or a nonmalignant respiratory disease.

Did the person who became ill participate in a uranium miner study for either St. Mary's Hospital or the University of New Mexico School of Medicine?

Yes, St. Mary's [ ] Yes, University of New Mexico [ ] No [ ]

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

In order for you to establish that the person who became ill contracted a compensable disease, you will need to submit certain medical documents that show a diagnosis of a compensable disease. For a complete list of the specific documents required for each illness, consult the medical records attachment at the end of this claim form.

To certify the record, ask your 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."

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): _____

☐ I WANT THE RADIATION PROGRAM TO CONTACT ONE OF THE CANCER REGISTRIES LISTED BELOW. 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 lung or renal cancer 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 this cancer, please mark the box next to the appropriate state. You will also need to complete and sign the medical release on page 14.***

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

Part 11: PREVIOUS PAYMENTS OF MONEY.

Please answer the following question:

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

YES [ ] NO [ ]

If you checked "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 payment.

NOTE REGARDING ADDITIONAL COMPENSATION AND MEDICAL BENEFITS UNDER THE ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT (EEOICPA): The EEOICPA statute provides certain individuals approved for compensation under the Radiation Exposure Compensation Act with additional compensation and benefits through a program administered by the Department of Labor. Section 5 claimants, i.e., uranium miners, uranium millers, and uranium ore transporters, are eligible to receive an additional $50,000 lump sum payment plus medical benefits for the condition for which they were approved under the Radiation Exposure Compensation Act. The EEOICPA Program will provide medical benefits from the date your EEOICPA claim form is filed. Thus, it is in your best interest to file your claim form with the EEOICPA Program as soon as possible. If you would like more information about EEOICPA, you can call the Department of Labor's toll-free call center at 1-866-888-3322 or you can visit the Department of Labor's website at www.dol.gov.

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 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 the attorney's active membership in 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 only correspond and communicate with your attorney on matters related to of 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 theRadiation 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, D.C. 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
Civil Division

AUTHORIZATION TO RELEASE EMPLOYMENT, MEDICAL, AND OTHER INFORMATION

To: National Institute for Occupational Safety and Health
St. Mary's Hospital and Medical Center
University of New Mexico Medical School
New Mexico Tumor Registry

The undersigned hereby authorizes the release of any and all employment, medical, and other information concerning the individual whose name appears on line 1 to a representative of the Radiation Exposure Compensation Program (RECP), Department of Justice. This authorization specifically authorizes release of all information gathered in the course of health related studies of uranium miners, uranium mill workers, and any individual who was employed in the transport of uranium ore or vanadium-uranium ore, including, but not limited to: identification and birth date information, employment history, and medical condition information. 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 this claim _____ Date _____

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

If you would like the Radiation Program staff 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 information relating to me from my claim to:

Print or Type Name _____ Relationship to Requester _____

Phone Number _____ Current Address _____

Signature of individual authorizing this release _____ Date _____

[1] Individuals requesting information 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 theRadiation 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 records which the Radiation Exposure Compensation Program (RECP) will accept as proof that the person who became ill contracted **lung cancer, pulmonary fibrosis, fibrosis of the lung, cor pulmonale related to fibrosis of the lung, silicosis, pneumoconiosis, renal cancer, or chronic renal disease (including nephritis and kidney tubal tissue injury.)**

Tear off this attachment and take it to the doctor or hospital holding the records of the person who became ill with **lung cancer, pulmonary fibrosis, fibrosis of the lung, cor pulmonale related to fibrosis of the lung, silicosis, pneumoconiosis, renal cancer, or chronic renal disease (including nephritis and kidney tubal tissue injury.)**

Show this list to the doctor or hospital and ask them to give you original or certified copies of the required medical documentation listed below. Submit the record(s) containing a diagnosis of the disease, if possible. Otherwise, send the records below that are available. Call the RECP if you have any questions at 1-800-729-7327.

Additionally, medical documentation establishing that onset of the illness occurred after the relevant milling employment may be required. If necessary, the RECP will advise you as to what records need to be provided.

I. **Lung Cancer**

A. If the person with lung cancer is **deceased or living**, any of the following records may be submitted as proof of the disease:

1. Pathology report of tissue biopsy, 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; or
   g. sputum cytology;
2. Autopsy report;
3. Bronchoscopy report;
4. One of the following summary medical reports:
   a. physician summary report;
   b. hospital discharge summary report;
   c. operative report;
   d. radiation therapy summary report; or
   e. oncology summary or consultation report;
5. Reports of the radiographic studies, including:
   a. x-rays of the chest;
   b. chest tomograms;
   c. computer-assisted tomography (CT); or
   d. magnetic resonance imaging (MRI); or
6. Death certificate, provided that it is signed by a physician at the time of death.

II. **Pulmonary Fibrosis, Fibrosis of the Lung, Silicosis, or Pneumoconiosis**

A. If the person with pulmonary fibrosis, fibrosis of the lung, silicosis or pneumoconiosis is **deceased**, any of the following forms of medical documentation may be submitted:

1. Pathology report of tissue biopsy;
2. Autopsy report;
3. If an x-ray exists, the x-ray **and** interpretive reports of the x-ray by a maximum of two

NIOSH certified "B" readers, classifying the existence of disease of category 1/0 or higher according to a 1989 report of the International Labor Office (known as the "ILO"), or subsequent revisions;

4. If no x-rays exist, an x-ray report;
5. Physician summary report;
6. Hospital discharge summary report;
7. Hospital admitting report;
8. Death certificate, provided that it is signed by a physician at the time of death; or
9. Documentation specified below in section (II)(B).

B. If the person with pulmonary fibrosis, fibrosis of the lung, silicosis, or pneumoconiosis is **living**, at a minimum the following medical records must be submitted:

Either:

1. An arterial blood gas study administered at rest in a sitting position, or an exercise arterial blood gas test; **or**
2. Written diagnosis by a physician as described in the regulations at § 79.51(s);

And one of the following:

3. A chest x-ray administered in accordance with standard techniques accompanied by interpretive reports of the x-ray by a maximum of two NIOSH certified "B" readers, classifying the existence of disease of category 1/0 or higher according to a 1989 report of the International Labor Office (known as the "ILO"), or subsequent revisions; or
4. High-resolution computed tomography scans (commonly known as "HRCT scans") including computer assisted tomography scans (commonly known as "CAT scans"), magnetic resonance imaging scans (commonly known as "MRI scans"), and positron emission tomography scans (commonly known as "PET scans") and interpretive reports of such scans;
5. Pathology reports of tissue biopsies; or
6. Pulmonary function tests indicating restrictive lung function and consisting of three reproducible time/volume tracings recording the results of the forced expiratory volume in one second (FEV1) and the forced vital capacity (FVC) administered and reported in accordance with the Standardization of Spirometry–1994 Update by the American Thoracic Society, and reflecting values for FEV1 or FVC that are less than or equal to the lower limit of normal for an individual of the claimant's age, sex, height, and ethnicity.

III. **Cor Pulmonale Related to Fibrosis of the Lung**

If the person with cor pulmonale related to fibrosis of the lung is **deceased,** please provide the same documentation as is required for proof of pulmonary fibrosis, fibrosis of the lung, silicosis, and pneumoconiosis in section (II)(A) above. If the person with cor pulmonale related to fibrosis of the lung is **living,** please provide the same documentation as is required for proof of pulmonary fibrosis, fibrosis of the lung, silicosis, and pneumoconiosis in section (II)(B) above.

C. **Additionally,** if the person with cor pulmonale related to fibrosis of the lung is **deceased or living,** provide one or more of the following medical records:

1. Right heart catheterization;
2. Cardiology summary or consultation report;
3. Electrocardiogram;
4. Echocardiogram;
5. Physician summary report;
6. Hospital discharge report;
7. Autopsy report;
8. Report of physical examination; or
9. Death certificate, provided that it is signed by a physician at the time of death.

IV. **Renal Cancer**

A claimant or beneficiary may submit any of the following forms of medical documentation:

A. Pathology report of tissue biopsy or resection;

B. Autopsy report;

C. One of the following summary medical reports:

1. Physician summary report;
2. Hospital discharge summary report;
3. Operative report;
4. Radiotherapy summary report;
5. Medical oncology summary or consultation report;

D. Report of one of the following radiology examinations:

1. Computerized tomography (CT) scan;
2. Magnetic resonance imaging (MRI); or

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

V. **Chronic Renal Disease (including nephritis and kidney tubal tissue injury)**

A claimant or beneficiary may submit any of the following forms of medical documentation:

A. Pathology report of tissue biopsy;

B. If laboratory or radiographic tests exist:

1. Abnormal plasma creatinine values; and
2. Abnormal glomerular filtration rate (by either measured creatinine or iothalamate clearance or calculated by MDRD equation); and
3. Renal tubular dysfunction as evidenced by:
   a. glycosuria in the absence of diabetes mellitus;
   b. proteinuria less than 1 gram daily without other known etiology; or
   c. hyperphosphaturia, aminoaciduria, B-2 microglobinuria or alkaline phosphaturia or other marker of proximal tubular injury; or
4. Radiographic evidence of chronic renal disease;

C. Autopsy report;

D. Physician summary report;

E. Hospital discharge summary report;

F. Hospital admitting report; or

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