Instructions to Claimant: Please complete the questions included in this claim form as your submission for compensation from the September 11th Victim Compensation Fund ("VCF"). This form includes both the eligibility and compensation portions of your claim.

When completing this claim form, you must:

- Complete the form on a computer by filling out the PDF-fillable version **or** print out the form and fill out your answers by hand using black or blue ink.
- Submit your answers in English. When filling out this form please use your full legal name.
- Use either of the following to make your selection when answering a question that has a box or a circle:

  "✓" - or - "**X**"
- Submit the signed Signature Page with your completed claim form.
- Review the document checklist for required documentation based on your specific circumstances. The checklist is provided to assist you in gathering and submitting the documents needed to process your claim. You do not need to send the document checklist back to the VCF.

The VCF keeps all documents you submit with your claim. Please make copies for your records of any documents you submit, including a copy of your completed claim form.

Appendices:

There are several appendices to the Hard Copy Claim Form:

Appendix A: Additional Required Information for Claims Filed for Deceased Individuals
Appendix B: Presence at the Pentagon and Shanksville, PA Sites
Appendix C: Private Physician Packet – NYC Site
Appendix D: Private Physician Packet – Pentagon & Shanksville, PA Sites

Mailing Your Form:

To submit your Hard Copy Claim Form, mail the form, appendices, and any supporting documents needed to process your claim to:

Mailing Address:
September 11th Victim Compensation Fund
P.O. Box 34500
Washington, D.C., 20043

Overnight Deliveries:
September 11th Victim Compensation Fund
Claims Processing Center
1220 L Street NW
Suite 100 - Box 408
Washington, DC 20005-4018

Please be sure all documents you submit have the victim's Social Security Number printed at the top of the page.

If you need assistance completing this form, or have any questions, **please call our toll-free Helpline at 1-855-885-1555**. For the hearing impaired, call 1-855-885-1558 (TDD). If you are calling from outside the United States, call 1-202-514-1100.

PART I – VICTIM AND CLAIMANT INFORMATION

The term "Victim" refers to the individual who has been diagnosed with a September 11th-related physical injury or condition. The term "Claimant" refers to the individual who is filing the claim to seek compensation for the victim. Individuals who are filing a Personal Injury claim on their own behalf are both the claimant and the victim.

INFORMATION ABOUT THE VICTIM

1. Complete the information below for the individual who has been diagnosed with a 9/11-related physical injury or condition. Please use the individual's full legal name.

Last Name	First Name	Middle Name

Mailing Address	Apartment/Suite Number

City	State/Province	Zip/Postal Code	Country (if not the U.S.)

Best Telephone Number during Business Hours	Alternate Telephone Number(s)

Email Address	
Date of Birth (mm/dd/yyyy)	

Is the victim a U.S. citizen? ○ Yes ○ No

If **Yes**, provide the victim's Social Security Number or Taxpayer Identification Number:

If **No**, provide the following:

National Identification Number	Country of Citizenship	Passport Number	Passport Country

Has the victim ever gone by any other names (e.g., maiden name)? ○ Yes ○ No

If **Yes**, list all former names:

Last	First	Middle

INFORMATION ABOUT THE CLAIMANT

2. In what capacity are you filing the claim on behalf of the victim? Select <u>one</u> from the list below:

- ○ **Self** – I am the victim. You do not need to complete the remaining information in this section – *skip to Question 5.*
- ○ **Personal Representative of a deceased individual.** You must also complete Claim Form Appendix A.
- ○ **Parent or Guardian of a minor.** Please provide additional information below:
  - ○ I have sole legal custody of the minor.
  - ○ I share or have joint legal custody of the minor.
- ○ **Guardian of a non-minor.**

If there is more than one Personal Representative or if you share Joint Custody of a minor, you also need to complete Question 4.

If you are an attorney who is completing this form on your client's behalf, complete the information below about the claimant and then provide your information in Question 5.

If you are the claimant and there is someone who you would like to be able to speak on your behalf or find out information about the claim (e.g., a spouse or a child), provide their contact information in Question 6.

3. Complete the following information for the claimant:

Last Name	First Name	Middle Name

Mailing Address	Apartment/Suite Number

City	State/Province	Zip/Postal Code	Country (if not the U.S.)

Best Telephone Number during Business Hours	Alternate Telephone Number(s)

Email Address	
Relationship to Victim	
Date of Birth (mm/dd/yyyy)	

Is the claimant a U.S. citizen? ○ Yes ○ No

If **Yes**, provide the claimant's Social Security Number or Taxpayer Identification Number:

If **No**, provide the following:

National Identification Number	Country of Citizenship	Passport Number	Passport Country

4. If applicable, complete the following information about any co-Personal Representatives or the person with whom you share joint custody. *Note: both signatures are required wherever the VCF asks for a signature.* **If there are more than two Personal Representatives of a deceased individual, please attach additional pages as the VCF needs the information below for all co-Personal Representatives. Please see the VCF website for additional information specific to co-Personal Representatives.**

Last Name	First Name	Middle Name

Mailing Address	Apartment/Suite Number

City	State/Province	Zip/Postal Code	Country (if not the U.S.)

Relationship to Claimant	

Date of Birth (mm/dd/yyyy)	Email Address	Telephone Number

Is the individual a U.S. citizen? ○ Yes ○ No

If **Yes**, provide the your Social Security Number or Taxpayer Identification Number:

If **No**, provide the following:

National Identification Number	Country of Citizenship	Passport Number	Passport Country

INFORMATION ABOUT THE CLAIMANT'S ATTORNEY (IF APPLICABLE)

5. If an attorney is representing you with this claim, fill out the information below:

Last Name	First Name	Middle Name

Law Firm Name	

Mailing Address	Apartment/Suite Number

City	State/Province	Zip/Postal Code	Country (if not the U.S.)

Email Address	Telephone Number

We strongly encourage all claimants who are represented by an attorney to submit their claim online. This will provide attorneys and claimants with instant access to the claim status, correspondence sent by the VCF, and the ability to upload documents directly to the claim. Visit www.vcf.gov and view our "*How to File a Claim*" page for full details on how to submit your claim online.

INFORMATION ABOUT ALTERNATIVE CONTACT (IF APPLICABLE)

6. If there is someone whom you would like to be able to speak on your behalf about your claim or to access information about your claim (e.g. a spouse or a child), list their contact information below. You do not need to list any individual whose information you have already provided.

Last Name	First Name	Middle Name

Mailing Address	Apartment/Suite Number

City	State/Province	Zip/Postal Code	Country (if not the U.S.)

Email Address	Telephone Number

PART II – ELIGIBILITY TO RECEIVE COMPENSATION

PRESENCE AT A 9/11-RELATED CRASH SITE

To be eligible for compensation from the VCF, the victim must have been present at a designated 9/11-related site from September 11, 2001 through May 30, 2002. If the victim was not present at some point during this timeframe or was not at a designated site, you are not eligible to file a claim for compensation.

7. On the list below, select the sites at which the victim was present at some point beginning September 11, 2001 through May 30, 2002.

☐ New York City ("NYC") Exposure Zone* – *continue to Question 8.*

*The "NYC Exposure Zone" is defined as "the area in Manhattan south of the line that runs along Canal Street from the Hudson River to the intersection of Canal Street and East Broadway, north on East Broadway to Clinton Street, and east on Clinton Street to the East River; and any area related to or along the routes of debris removal, such as barges and Fresh Kills landfill."

☐ Pentagon – *skip to Question 17 and complete Claim Form Appendix B.*

☐ Shanksville, PA – *skip to Question 17 and complete Claim Form Appendix B.*

In the questions that follow, the term "Responder" is defined as an individual who performed rescue, recovery, demolition, debris cleanup, or other related services at one of the sites in response to the September 11, 2001 terrorist attacks, regardless of whether the individual was a state or federal employee or member of the National Guard or performed the services in some other capacity. Therefore, the victim may be considered a responder even if he or she performed the listed services through a private employer or on a volunteer basis.

8. Why was the victim present in the NYC Exposure Zone during the period beginning September 11, 2001 through May 30, 2002?

☐ Part of the rescue, recovery, and debris clean-up – *continue to Question 9*.

☐ Through his or her ordinary employment as a non-responder – *continue to Question 9*.

☐ Lived in the NYC Exposure Zone – *skip to Question 15.*

☐ Other: *Specify and skip to Question 16*:

9. Select from the list below the employer or entity for which the victim worked or volunteered at the NYC Exposure Zone during the time period beginning September 11, 2001 through May 30, 2002. If the victim worked or volunteered for more than one entity on the list, you will need to complete this section for each entity by copying these pages, completing them for each entity, and submitting them with your claim form.

☐ FDNY – specify the victim's role from the following list:
- ○ Active FDNY firefighter or fire officer
- ○ Retired FDNY officer
- ○ FDNY EMS worker
- ○ FDNY engineer, dispatcher, electrician, or other position – specify:_____

☐ NYPD – specify the victim's role from the following list:
- ○ Police Officer
- ○ Other – specify: _____

☐ City of New York - select from the following list:
- ○ New York City Department of Corrections
- ○ New York City Department of Design and Construction
- ○ New York City Department of Environmental Protection
- ○ New York City Department of Sanitation
- ○ New York City Department of Transportation

- New York City Morgue
- New York City Transit Authority (MTA)
- Office of Chief Medical Examiner
- Other – specify: _____

☐ Port Authority – select from the following list:

- Port Authority of New York and New Jersey Police
- Port Authority Trans-Hudson Corporation (PATH)
- Other – specify: _____

☐ State of New York – select from the following list:

- New York State Department of Environmental Services
- New York State Police
- New York State Unified Court System (includes New York City Courts)
- National Guard
- Other – specify: _____

☐ Federal Government – select from the following list:

- Federal Bureau of Investigation (FBI)
- FEMA
- National Guard
- Secret Service
- U.S. Corps of Engineers
- U.S. Coast Guard
- U.S. Environmental Protection Agency
- U.S. Marshall Service
- Other – specify: _____

☐ Consolidated Edison

☐ Empire Blue Cross Blue Shield

☐ Lucent Technologies

☐ Red Cross

☐ Salvation Army

☐ Verizon

☐ Other employer or entity – provide name of company or organization:

☐ Cleaning Company – specify: _____

☐ Construction Company – specify: _____

☐ Trucking or Transport Company – specify: _____

Questions 10-14 should be answered specific to the entity you selected in Question 9.

10. Indicate below if the victim was an employee, a contractor, or a volunteer:

☐ **Employee**

Provide the employer's address, including a name and contact information for any known supervisors/points of contact:

Employer Address:

Supervisor Name:

Contact Details:

List the victim's dates of employment with this organization:

Is this employer still in business? ○ Yes ○ No ○ Do Not Know

☐ **Contractor**

Provide the employer's name and address, including contact information for any known supervisors/points of contact:

Employer Address:

Supervisor Name:

Contact Details:

List the victim's dates of employment with this organization:

Is this employer still in business? ○ Yes ○ No ○ Do Not Know

☐ **Volunteer**

11. If the victim was a member of an employee union when working or volunteering for the selected entity, select the union(s) from the list below:

- ☐ District Council 37 (DC-37)
- ☐ Communication Workers of America (CWA)
- ☐ Consolidated Edison (CECONY Management and CECONY Weekly – Local 1-2)
- ☐ 32-BJ – Building Services Program A
- ☐ Local 1 – Plumbers of New York City
- ☐ Local 3 – IBEW
- ☐ Local 6 – New York Hotel Trades Council
- ☐ Local 11 – District Council of Iron Workers of Northern New Jersey
- ☐ Local 12A – Asbestos Workers
- ☐ Local 14 14B – International Union of Operating Engineers Benefit Fund
- ☐ Local 15 - International Union of Operating Engineers
- ☐ Local 30 – International Union of Operating Engineers Benefit Fund
- ☐ Local 40 and 361 Benefit Fund – New York City Iron Workers
- ☐ Local 46 – Metal Lathers

- ☐ Local 66 – General Building Laborers
- ☐ Local 78 - Asbestos, Lead & Hazardous Waste Laborers and Local 79 - General Building Laborers'
- ☐ Local 94 - International Union of Operating Engineers
- ☐ Local 197 - Stone Derrickmen and Riggers
- ☐ Local 282 - New York City & Long Island Teamsters
- ☐ Local 456 – Teamsters
- ☐ Local 469 – Teamsters
- ☐ Local 580 - Architectural and Ornamental Iron Workers
- ☐ Local 638 - Steamfitters Construction Trades
- ☐ Local 731 – Excavators
- ☐ Local 780 - Cement Masons
- ☐ Local 825 – International Union of Operating Engineers Benefit Fund
- ☐ Local 831 – Uniformed Sanitationmen's Association and Teamsters Joint Council 16
- ☐ Local 1010 and 1018 – Pavers and Road Builders District Council Benefit Fund
- ☐ 1199 Service Employees International Union (SEIU) – Health Care Employees
- ☐ New York City District Council of Carpenters
- ☐ Other union – specify:

12. Select from the list below the location where the victim worked or volunteered for the selected entity while at the NYC Exposure Zone during the time period beginning September 11, 2001 through May 30, 2002:

- ☐ On or adjacent to the pile/in the pit
- ☐ Staten Island/Fresh Kills Landfill
- ☐ Employer's address as provided in Question 10
- ☐ Other address within the NYC Exposure Zone – provide the cross streets if known:

13. Identify the dates (or range of dates) on which the victim worked or volunteered for the selected entity while at the NYC Exposure Zone:

14. Approximately how any hours per day was the victim present on the dates listed above?

If you have answered Questions 9-14 and did not also live in the NYC Exposure Zone, skip to Question 17.

15. Did the victim live within the NYC Exposure Zone during the time period beginning September 11, 2001 through May 30, 2002?

○ Yes ○ No

If **Yes,** provide the address where the victim lived:

Provide the dates on which the victim physically resided in the Zone:

16. Was the victim present within the NYC Exposure Zone during the time period beginning September 11, 2001 through May 30, 2002 in a capacity other than those listed in the previous questions?

○ Yes ○ No

If **Yes**, why was the victim present in the NYC Exposure Zone?

○ Visitor ○ Other - specify:

Identify the closest location within the NYC Exposure Zone where the victim was present, including buildings and/or cross streets:

Identify the dates (or range of dates) on which the victim was present in the NYC Exposure Zone:

Approximately how many hours per day was the victim present on the dates listed above?

INFORMATION ABOUT THE VICTIM'S PRIOR CLAIM WITH THE SEPTEMBER 11TH VICTIM COMPENSATION FUND (IF APPLICABLE)

17. Did the victim file a claim with the original September 11th Victim Compensation Fund of 2001?

○ Yes ○ No

If **Yes**, did the victim receive an award from the original September 11th Victim Compensation Fund of 2001?

○ Yes ○ No ○ Do Not Know

INFORMATION ABOUT THE VICTIM'S PARTICIPATION IN LAWSUITS RELATED TO SEPTEMBER 11, 2001 (IF APPLICABLE)

18. Has the victim or any dependent, spouse or beneficiary filed a lawsuit or been a party to a lawsuit in any court for personal injury damages that resulted from the September 11, 2001 attacks (including damages related to debris removal)?

○ Yes ○ No ○ Do Not Know

If **Yes**, which lawyer or law firm(s) represented the victim in the lawsuit?

Was the lawsuit dismissed or withdrawn? ○ Yes ○ No ○ Do Not Know

If **Yes**, on what date was the lawsuit dismissed or withdrawn?

Was the lawsuit settled? ○ Yes ○ No ○ Do Not Know

If **Yes**, was it settled with all defendants or only some defendants? ○ All ○ Some

On what date was the release signed?

19. Has the victim or any dependent, spouse or beneficiary filed any other claims/lawsuits in relation to the 9/11-related physical injury or condition?

○ Yes ○ No

If **Yes**, provide details of that lawsuit here:

INFORMATION ABOUT THE VICTIM'S 9/11-RELATED PHYSICAL INJURY OR CONDITION

To be eligible for compensation from the VCF, you must have a physical injury or condition caused by the terrorist-related aircraft crashes of September 11, 2001, or the rescue, recovery, and debris removal efforts during the immediate aftermath. You may not claim compensation for any mental health conditions. Conditions such as PTSD or anxiety are not eligible for compensation from the VCF.

If your physical injury or condition is certified for treatment by the WTC Health Program, the VCF will generally find the injury or condition eligible for compensation. If you are not being treated by the WTC Health Program, **you must seek certification for your condition(s) through the WTC Health Program.** In very limited circumstances, the VCF may evaluate the eligibility of the physical injury or condition through the Private Physician process.

20. Complete the table below. When providing dates, you should be as specific as possible. If you do not know the exact date, provide the month and year.

Name of Condition	When did the victim first begin experiencing symptoms? (Provide date)	What was the victim's first date of diagnosis?	Has any federal, state, or local government agency determined that this condition is the result of 9/11-related exposure?	If Yes, what is the name of the entity (e.g. WTC Health Program, FDNY, SSA, Workers' Compensation) that determined the condition is related?	If Yes, what was the date the victim was notified?
			○ Yes ○ No ○ Do Not Know		
			○ Yes ○ No ○ Do Not Know		
			○ Yes ○ No ○ Do Not Know		
			○ Yes ○ No ○ Do Not Know		
			○ Yes ○ No ○ Do Not Know		

*If your conditions are being treated by a physician **not** affiliated with the WTC Health Program, you must seek certification for the condition(s) from the WTC Health Program in order for the VCF to confirm the condition(s) is eligible for compensation. In very limited circumstances, the VCF may evaluate the eligibility of the condition through the Private Physician process. Information on the criteria for the Private Physician process can be found on the VCF website under "Forms and Resources." If you are **not** a candidate for the Private Physician process, and you submit the Private Physician forms, the information will **not** be considered by the VCF during review of your claim.*

PART III – COMPENSATION

21. What losses are you seeking for the victim's 9/11-related physical injury or condition? Select all that apply.

☐ Non-economic Loss (i.e. pain and suffering) – *If you are claiming non-economic loss only, skip to Question 29.*

☐ Replacement Services – *you must complete Questions 22 and 29-32.*

☐ Temporary Loss of Earnings – *you must complete Questions 23 and 29-32.*

☐ Permanent Loss of Earnings – *you must complete Questions 24-32.*

REPLACEMENT SERVICES

Replacement services are household services that the victim provided to the household. Such services include cleaning, cooking, child care, home maintenance and repairs, and financial services, among many others. Replacement services loss is intended to replace something that was lost – that is, something the victim used to do and now cannot do because of a 9/11-related eligible physical injury or condition.

In order to be compensated for replacement services, you must demonstrate that the victim performed the claimed service before the onset of his or her eligible physical injury or condition, and show that the eligible injury or condition now prevents or limits the victim from performing the service.

22. If you are seeking compensation for replacement services, complete the table below:

Type of services the victim performed prior to the onset of the 9/11-related physical injury or condition:	Hours spent per week performing the services:	When did the victim stop or reduce the amount of time spent per week performing these activities?	Which 9/11-related physical injury or condition prevents the victim from performing this activity?

LOSS OF EARNINGS

Loss of earnings can be claimed for a permanent inability to work due to a 9/11-related physical disability, or for a temporary inability to work due to a 9/11-related physical injury or condition. A permanent inability to work is one that is expected to last for the rest of the victim's worklife (that is, the victim is expected never to be able to return to work), and for which a third party has made a determination of permanent disability. A temporary inability to work is one that has already resolved, or is expected to resolve before the end of the victim's worklife (that is, the victim has already returned to work, or expects to be able to return to work in the future), whether or not a third party has made a temporary disability determination.

23. If you are seeking compensation for temporary loss of earnings, provide information about the victim's employment, including the specific time periods/dates when the victim missed work and the loss of earnings/benefits associated with the time missed from work as a result of the 9/11-related physical injury or condition:

Did any government agency, insurer, or physician, make a formal determination of temporary disability?

○ Yes ○ No ○ Do Not Know

Name of Employer(s):	Describe the specific time periods/dates the victim missed work as a result of the 9/11-related physical injury or condition (i.e. work missed for which the victim was not and will not be compensated):	Describe the loss of earnings and/or other benefits associated with the time missed from work as a result of the victim's 9/11-related physical condition or injury:

24. If you are seeking compensation for permanent loss of earnings due to the victim's 9/11-related physical disability, complete the following information. ***Otherwise, skip to Question 29.***

Is the disability a result of a 9/11 physical condition/injury? ○ Yes ○ No

Is the victim partially or totally disabled? ○ Partial ○ Total

Is the disability permanent or temporary? ○ Permanent ○ Temporary

Has any government agency, insurer, or physician made a formal determination with respect to the victim's disability? ○ Yes ○ No ○ Do Not Know

If **Yes**, what entity issued the determination? Identify all that apply from the list below:

☐ Social Security Administration ☐ NYCERS

☐ FDNY ☐ NYSLRS

Was the victim found to be disabled under the WTC Bill? ○ Yes ○ No ○ Do Not Know

If **Yes**, was the victim re-classified under the WTC Bill? ○ Yes ○ No ○ Do Not Know

☐ NYPD

☐ State Workers' Compensation - identify state:

☐ Insurance Company - specify:

☐ Physician - specify:

☐ Other - specify:

If **No**, what is the status of the application? ○ Denied ○ Pending ○ Do Not Know

25. To what entity did you submit the application?

☐ Social Security Administration ☐ NYCERS

☐ FDNY ☐ NYSLRS

☐ NYPD

☐ State Workers' Compensation - identify state:

☐ Insurance Company - specify:

☐ Physician - specify:

☐ Other - specify:

If you are certified by the WTC Health Program for at least one condition and do not already have a disability determination for an eligible condition from one of the standard third-party entities or sources (e.g., Social Security Administration, FDNY/NYPD, a state Workers' Compensation program, or insurance company) you may be eligible for a disability evaluation through the WTC Health Program Disability Evaluation process. This process is not for everyone. To learn more about this process and the criteria, visit "Forms and Resources" on the www.vcf.gov website.

If you are interested in seeking a disability evaluation through the WTC Health Program, check here: ☐

26. Complete the information below regarding the victim's employment and compensation history. For Personal Injury claims, provide the employment and compensation history for the three years prior to the decrease in earnings caused by the eligible condition. For Deceased claims, provide the victim's employment and compensation history for the three years prior to the victim's death and, if applicable, for the three years prior to any decrease in the victim's earnings caused by an eligible condition. If needed, attach additional pages.

Identify the victim's employer at the time the victim became disabled:

List the dates of employment for this job:

Is the victim currently working? ○ Yes ○ No ○ Do Not Know

If **No**, date of last day of work:

Did the victim receive health care benefits through this employer? ○ Yes ○ No ○ Do Not Know

27. Did the victim's employer offer a <u>Defined Benefit Pension Plan</u>?

○ Yes ○ No ○ Do Not Know

If **Yes**, is the victim currently receiving a pension?

○ Yes ○ No ○ Do Not Know

If **Yes**, complete the table below:

Pension Amount (Dollar Amount $)	**Frequency** (Weekly, Bi-weekly, Monthly or Quarterly)	**Type of Pension** (Regular, Service or Disability)

Did the victim's employer offer a <u>Defined Contribution Plan</u>, for example, a 401(k) or 403(b)?

○ Yes ○ No ○ Do Not Know

If **Yes**, was the percentage matching contribution higher than 4%? ○ Yes ○ No

If **Yes**, please indicate the percentage:

28. Did the victim receive any other benefits from this employer?

○ Yes ○ No ○ Do Not Know

If **Yes**, identify:

COLLATERAL SOURCE PAYMENTS

You are required to identify any compensation or benefits the victim has received, or is entitled to receive, from other sources with regards to his or her physical injury or condition as a result of the terrorist-related aircraft crashes of September 11, 2001 or the debris removal efforts. Under the Air Transportation Safety and System Stabilization Act, Public Law 107-42 (2001), the Special Master is required to reduce the compensation award by the amount of collateral source compensation the victim has received, or is entitled to receive, as a result of the terrorist-related aircraft crashes of September 11, 2001 or the debris removal efforts.

29. Has the victim applied to receive any payments from the Social Security Administration or from workers' compensation programs as a result of the 9/11-related physical injury or condition? This includes uniformed service benefits similar to Social Security or workers' compensation.

○ Yes ○ No ○ Do Not Know

If **Yes**, identify the program(s) or benefit(s) applied for and the status of the application:

Program(s) / Benefit(s)	Status (Approved, Denied, or Pending)

30. Has the victim received, or is the victim entitled to receive, payments from a private disability insurance carrier as a result of the 9/11-related physical injury or condition?

○ Yes ○ No ○ Do Not Know

If **Yes,** was this coverage held personally or through the victim's employer?

○ Personally Held ○ Through Employer

Is the victim currently receiving these disability payments? ○ Yes ○ No ○ Do Not Know

31. Has the victim received, or is the victim entitled to receive, any other payments as compensation as a result of the 9/11-related physical injury or condition, such as a Public Safety Officers' Benefit (PSOB) payment? You do not need to include any charitable contributions.

○ Yes ○ No ○ Do Not Know

If **Yes**, identify and describe below the payments the victim received:

32. Have the victim's dependents received or applied for any benefits from the Social Security Administration or any other government entity as a result of the victim's 9/11-related physical injury or condition?

○ Yes ○ No ○ Do Not Know

If Yes, identify the program and the status of the application:

**Complete an Exhibit 1 – SSA Consent Form for any dependent who is receiving benefits.*

PART IV- OTHER INFORMATION IN SUPPORT OF APPLICATION

Use the area below (and any additional pages) to provide any other information that you believe may be relevant to the individual circumstances of your claim and the calculation of the economic and non-economic loss or collateral offsets. You may also submit any additional documents not already requested that you believe might be relevant.

By submitting this form, you are agreeing that you understand the notices below (continued on the following page) regarding your waiver of rights, the Privacy Act, and authorization to communicate with your attorney or other authorized representative.

Waiver of Right to file Lawsuit:

By submitting this form, you are waiving the right to file a civil action (or to be a party to any action) in any Federal or State court for damages sustained as a result of the terrorist-related aircraft crashes of September 11, 2001. For claimants filing on a victim's behalf, this waiver may apply to anyone who might seek to represent that victim in such an action. The waiver does not apply to a civil action to recover collateral source compensation, or to a civil action against any person who is a knowing participant in any conspiracy to hijack any aircraft or commit a terrorist act.

Privacy Act Notice:

By submitting this form, you are authorizing the U.S. Department of Justice to collect this information as allowed by the September 11th Victim Compensation Fund of 2001, Title IV of Public Law 107-42, Air Transportation Safety and System Stabilization Act, 49 U.S.C. § 40101 note, as amended by the James Zadroga 9/11 Health and Compensation Act of 2010, Title II of Public Law 111-347, and reauthorized by the James Zadroga 9/11 Victim Compensation Fund Reauthorization Act, Division O, Title IV of Public Law 114-113. The information you submit in your claim is for official use by the U.S. Department of Justice for the purposes of determining your eligibility for, and the amount of, compensation you may receive under your claim to the Victim Compensation Fund. Provision of this information is voluntary; however, failure to provide complete information may result in a delay in processing or a denial of your claim. Information you submit regarding your claim may be disclosed by the Department of Justice only in accordance with the provisions of the Privacy Act, and for the routine uses indicated below:

1. Where a record, either alone or in conjunction with other information, indicates a violation or potential violation of law – criminal, civil, or regulatory in nature – to the appropriate federal, state, local, territorial, tribal, or foreign law enforcement authority or other appropriate entity charged with the responsibility for investigating or prosecuting such violation or charged with enforcing or implementing such law.

2. To any person or entity that the Special Master or the Special Master's designee has reason to believe possesses information regarding a matter relating to the Victim Compensation Fund or the administration thereof, to the extent deemed to be necessary by the Special Master or her designee in order to elicit such information or cooperation from the recipient for use in the performance of an authorized activity of the Fund.

3. In an appropriate proceeding before a court, grand jury, or administrative or adjudicative body, when the Department of Justice determines that the records are arguably relevant to the proceeding; or in an appropriate proceeding before an administrative or adjudicative body when the adjudicator determines the records to be relevant to the proceeding.

4. To an actual or potential party to litigation or the party's authorized representative for the purpose of negotiation or discussion of such matters as settlement, plea bargaining, or in informal discovery proceedings.

5. To the news media and the public, when information related to a claim is at issue in another civil or criminal proceeding, unless it is determined that release of the specific information in the context of a particular case could constitute an unwarranted invasion of personal privacy.

6. To contractors, grantees, experts, consultants, students, and others performing or working on a contract, service, grant, cooperative agreement, or other assignment for the federal government, when necessary to accomplish an agency function related to the administration of the Fund.

7. To a former employee of the Department for purposes of: responding to an official inquiry by a federal, state, or local government entity or professional licensing authority, in accordance with applicable Department regulations; or facilitating communications with a former employee that may be necessary for personnel-related or other official purposes where the Department requires information and/or consultation assistance from the former employee regarding a matter within that person's former area of responsibility.

8. To a Member of Congress or staff acting upon the Member's behalf when the Member or staff requests the information on behalf of, and at the request of, the individual who is the subject of the record.

9. To the National Archives and Records Administration for purposes of records management inspections conducted under the authority of 44 U.S.C. §§ 2904 and 2906.

10. To such recipients and under such circumstances and procedures as are mandated by federal statute or treaty.

11. Records relating to an individual who was notified that a Victim Compensation Fund award was subject to rescission or recoupment, and that the paid award amount was to be returned to the United States, where the individual has not complied, may be referred to the U.S. Department of the Treasury for collection under the Treasury Offset Program, as authorized by 31 U.S.C. 3716 and other applicable law.

By this submission, you authorize the U.S. Department of Justice to disclose any records or information relating to your Victim Compensation Fund claim for the routine uses identified above and for the purpose of determining qualification and/or compensation of your claim specifically to: agency contractors assisting in the administration of the Victim Compensation Fund; other federal, state, or local agencies, including the U.S. Department of Treasury and NIOSH; and other individuals or entities having information related to the claim, such as physicians, medical service providers, insurers, and employers.

Communication with your Attorney or Authorized Representative:

By submitting this form, you are authorizing the Special Master, the Special Master's designees, the U.S. Department of Justice or agency contractors assisting in the administration of the Victim Compensation Fund to contact your attorney or other persons authorized to act on your behalf (if identified in Part I. of this form) if the Special Master needs additional information or clarification about your claim.

Paperwork Reduction Act Notice:

This request is in accordance with the Paperwork Reduction Act of 1995. An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it contains a currently valid OMB approval number. We try to create forms and instructions that are accurate, can be easily understood, and that impose the least possible burden on you. It is estimated that respondents will complete the paper form in an average of 2 hours and the electronic form in an average of 1.5 hours.

Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Office of the Special Master, U.S. Department of Justice, 950 Pennsylvania Ave, NW, Washington, DC 20530; OMB control number 1105-0092.

September 11th
Victim Compensation Fund

Signature Page

OMB No: 1105-0092

Victim's SSN or National ID Number:

Instructions: Please review the following statements and initial where indicated. Sign and date the form, and print your name at the end of the form.

For all claimants, please initial in acknowledgement of the following:

Initials

I Understand the submission of this claim authorizes the Department of Justice to collect this information under the Privacy Act and I have read and understand the Privacy Act Notice provided. Consistent with that Notice, **I Consent** to the disclosure of any records or information relating to my Victim Compensation Fund claim for the routine uses described in that Notice, and I **Further Authorize** such disclosures for the purpose of determining qualification and/or compensation of my claim to: agency contractors assisting in the administration of the Victim Compensation Fund; other federal, state, or local agencies, including the U.S. Department of Treasury and NIOSH; and other individuals or entities having information related to the claim, such as physicians, medical service providers, insurers, and employers.

Initials

I Certify that the information provided in this application and any documents provided in support of this claim are true and accurate to the best of my knowledge, and I declare under penalty of perjury that the foregoing is true and correct. **I Understand** that false statements or claims made in connection with the application may result in fines, imprisonment and/or any other remedy available by law to the Federal Government, including as provided in 18 U.S.C. § 1001, and that claims that appear to be potentially fraudulent or to contain false information will be forwarded to federal, state, and local law enforcement authorities for possible investigation and prosecution.

Initials

I Authorize the U.S. Department of Justice to obtain any information relating to my claim under the September 11th Victim Compensation Fund of 2001 (Victim Compensation Fund or VCF) for the purpose of evaluating my claim for compensation to the VCF from individuals; employers; hospitals; medical service providers; other federal, state, or local agencies; or other sources having information relating to my claim. This information may include, but is not limited to, medical, government, and financial information (including pension records, pension files, or pension information) about me or the individual whom I represent. **I Further Authorize** individuals, entities, and federal, state and local agencies including NIOSH and the WTCHP, having information pertinent to my claim, to release such information to a duly accredited representative of the U.S. Department of Justice during the review of my claim to the Victim Compensation Fund, regardless of any previous agreement to the contrary. Copies of this authorization that show my signature are as valid as the original release signed by me. I acknowledge that I have the right to revoke this Authorization at any time, except to the extent that VCF and the entities listed above have already acted based on this Authorization. I understand that the knowing and willful request for, or acquisition of, a record pertaining to an individual under false pretenses is a criminal offense subject to a $5,000 fine.

For claimants with an attorney or other authorized representative or alternative contact, please initial in acknowledgement of the following:

Initials

I Authorize the Special Master, the Special Master's designees, the United States Department of Justice or agency contractors assisting in the administration of the Victim Compensation Fund to contact my attorney or other persons authorized to act on my behalf.

For claimants filing on behalf of a deceased individual, please initial in acknowledgement of the following:

Initials

I Certify that I have provided the required Notice of Filing of Claim to all of the decedent's living relatives and potentially interested parties by either personal delivery or certified mail, return receipt requested, and that I am not aware of anyone else to whom such notice should be provided. **I also Authorize** the U.S. Department of Justice to publish my name as well as the name of the deceased individual on whose behalf I am seeking compensation.

Signature of Claimant or Authorized Representative

Date of Signature (mm/dd/yyyy)

Print Name

ADDITIONAL INFORMATION FOR CLAIMS FILED FOR DECEASED INDIVIDUALS

This section is for claimants who are filing a claim on behalf of a deceased individual. This includes decedents who are believed to have died as a result of their 9/11-related physical injuries or conditions, and those who have died due to other causes.

1. **Have you been appointed by a court as the Personal Representative for the deceased individual?***

   ○ Yes ○ No

   If **No**, have you attempted to be appointed the Personal Representative by a court? ○ Yes ○ No

   If **Yes**, explain why you were not appointed as the Personal Representative by a court or attach a statement to your claim form with the explanation.

2. **Did the Decedent leave a will?***

   ○ Yes ○ No ○ Do Not Know

3. **Did the decedent previously file a Personal Injury claim with the re-opened September 11th Victim Compensation Fund?***

   ○ Yes ○ No ○ Do Not Know

   If **Yes**, enter the claim number here if known: VCF

4. **Did the decedent die as a result of his or her 9/11-related physical injury or condition?*** **Note:** If you are unsure if the decedent's death was caused by an eligible 9/11-related condition, you should follow the steps specific to victims who are believed to have died as a result of an eligible condition. If the VCF determines that the cause of death is not related to an eligible condition, we will update the claim and process it accordingly.

   ○ Yes ○ No

   If **Yes**, continue to Question 5. If **No**, *skip to Question 8.*

INFORMATION ABOUT ADDITIONAL LOSS FOR INDIVIDUALS WHO DIED AS A RESULT OF THEIR 9/11-RELATED PHYSICIAL INJURIES OR CONDITIONS

You may claim additional loss for an individual who died as a result of their 9/11-related physical injuries or conditions. These claims for loss are not applicable for individuals who did **not** die as result of their 9/11-related injuries or conditions. If the decedent died of other causes, please do not complete this section.

5. **Do you seek compensation for any out-of-pocket burial or memorial service expenses?**

   ○ Yes ○ No

   If yes, list the burial or memorial expenses below:

6. **How many people (other than the decedent) were living in the decedent's household at the time of the decedent's death?**

In the table below, list each individual who lived in the household:

Name	Date of Birth (mm/dd/yyyy)	Relationship to Decedent

7. Were there any individuals who were not living in the household who were receiving substantial financial support from the decedent at the time of death?

○ Yes ○ No ○ Do Not Know

If **Yes**, list each individual in the table below:

Name	Date of Birth (mm/dd/yyyy)	Relationship to Decedent	Type and amount of financial support provided

COLLATERAL SOURCE PAYMENTS FOR DECEDENTS' BENEFICIARIES

This section is applicable for individuals who died as a result of their 9/11-related physical injuries or conditions. The questions apply to the collateral source payments received by the decedent's beneficiaries as a result of his or her death.

Identify any compensation or benefits the decedent's beneficiaries or estate received, or are entitled to receive, from non-VCF sources as a result of the terrorist-related aircraft crashes of September 11, 2001 or the debris removal efforts. For example, if the decedent's beneficiaries received insurance or a specific payment from an employer that is not part of the normal compensation, these might be considered "collateral source" payments. Under the statute, the Special Master is required to reduce the compensation award by the amount of collateral source compensation a decedent or a decedent's beneficiaries or estate has received, or are entitled to receive, as a result of the terrorist-related aircraft crashes of September 11, 2001 or the debris removal efforts. Note: Settlement payments from September 11th-related lawsuits do not need to be listed again in this section.

8. Have the decedent's beneficiaries received or applied for any benefits from a death benefit program as a result of the decedent's death (other than insurance and charitable contributions)? Examples of these benefits include Public Safety Officers' Benefit payments.

○ Yes ○ No ○ Do Not Know

9. Have the decedent's beneficiaries applied to receive any payments from the Social Security Administration, workers' compensation programs, life insurance payments, or accidental death and dismemberment ("ADD") payments as a result of the decedent's death? This includes uniformed service benefits similar to Social Security or workers' compensation.

○ Yes ○ No ○ Do Not Know

If you answered **Yes** to either Questions 8 or 9 above, **OR** if beneficiaries have received any other payments as a result of the decedent's death, other than from charitable contributions, list them in the table below:

Source of Collateral Death Benefits (e.g. SSA*, Workers' Compensation, Life or ADD Insurance)	Status of the Application (Granted, Denied, Pending or Do Not Know)	Name of each beneficiary who has, is, or will be receiving payments:

** Complete an Exhibit 1 – SSA Authorization for each beneficiary who is receiving SSA survivor benefits. The authorization can be found under "Forms and Resources" on the www.vcf.gov website.*

10. Have the decedent's beneficiaries received any other payments as a result of the decedent's death (excluding charitable contributions)?

○ Yes ○ No ○ Do Not Know

If **Yes**, explain:

Notice to Individuals of Filing of Claim

You are required to notify the following people that you are filing a claim on behalf of the decedent:

- ✓ The immediate family of the decedent (including, but not limited to, the spouse, former spouse(s), children, other dependents, siblings, and parents);
- ✓ The executor/administrator and beneficiaries of the decedent's will;
- ✓ The beneficiaries of the decedent's life insurance policies; and,
- ✓ Any other person who may reasonably be expected to assert an interest in an award or to have a cause or action to recover damages relating to the wrongful death of the decedent.

The "Forms and Resources" page of the VCF website contains the notice you must provide to the required individuals. You are required to provide this notice to everyone in the four categories above, even if they are not included in the decedent's will.

Please complete the information in the following sections:

A. Decedent's Mother – this individual is:

Last Name	First Name	Middle Name

☐ This individual is deceased
☐ I do not know if this individual is living
☐ This individual is living but I am unable to locate this information
☐ This individual is living and the information is below

Mailing Address			Apartment/Suite Number
City	**State/Province**	**Zip/Postal Code**	**Country (if not the U.S.)**
Email Address			**Telephone Number**

B. Decedent's Father – this individual is:

Last Name	First Name	Middle Name

☐ This individual is deceased
☐ I do not know if this individual is living
☐ This individual is living but I am unable to locate this information
☐ This individual is living and the information is below

Mailing Address			Apartment/Suite Number
City	**State/Province**	**Zip/Postal Code**	**Country (if not the U.S.)**
Email Address			**Telephone Number**

C. Did the decedent have a spouse or partner?

○ Yes – spouse ○ Yes – partner ○ No

If **Yes – this individual is:**

Last Name	First Name	Middle Name

☐ This individual is deceased
☐ I do not know if this individual is living
☐ This individual is living but I am unable to locate this information
☐ This individual is living and the information is below

Mailing Address			Apartment/Suite Number
City	**State/Province**	**Zip/Postal Code**	**Country (if not the U.S.)**
Email Address			**Telephone Number**

D. Did the decedent have a former spouse or partner?

○ Yes – former spouse □ Yes – former partner □ No

If **Yes – this individual is:**

○ Deceased – *only name is required* □ Living but address unknown □ Living and information below:

Last Name	First Name	Middle Name

☐ This individual is deceased
☐ I do not know if this individual is living
☐ This individual is living but I am unable to locate this information
☐ This individual is living and the information is below

Mailing Address			Apartment/Suite Number
City	**State/Province**	**Zip/Postal Code**	**Country (if not the U.S.)**
Email Address			**Telephone Number**

E. Did the decedent have siblings?

○ Yes ○ No

If **Yes**, indicate how many siblings the decedent had, including siblings who are deceased: ☐

Complete the information below for each sibling. If the decedent had more than two siblings, identify each sibling by copying this page, completing a section for each sibling, and including the additional page(s) with the claim form submittal:

Sibling 1 – this individual is:

Last Name	First Name	Middle Name

☐ This individual is deceased
☐ I do not know if this individual is living
☐ This individual is living but I am unable to locate this information
☐ This individual is living and the information is below

Mailing Address			Apartment/Suite Number
City	**State/Province**	**Zip/Postal Code**	**Country (if not the U.S.)**
Email Address			**Telephone Number**

Sibling 2 – this individual is:

Last Name	First Name	Middle Name

☐ This individual is deceased
☐ I do not know if this individual is living
☐ This individual is living but I am unable to locate this information
☐ This individual is living and the information is below

Mailing Address			Apartment/Suite Number
City	**State/Province**	**Zip/Postal Code**	**Country (if not the U.S.)**
Email Address			**Telephone Number**

F. Did the decedent have dependents (including biological or adopted children)?

○ Yes ○ No

If **Yes**, indicate how many dependents the decedent had, including dependents who are deceased: ☐

Complete the information below for each dependent. If the decedent had more than two dependents, identify each dependent by copying this page, completing a section for each dependent, and including the additional page(s) with the claim form submittal:

Child/Dependent 1 – this individual is:

Last Name	First Name	Middle Name

☐ This individual is deceased
☐ I do not know if this individual is living
☐ This individual is living but I am unable to locate this information
☐ This individual is living and the information is below

Mailing Address			Apartment/Suite Number
City	**State/Province**	**Zip/Postal Code**	**Country (if not the U.S.)**
Email Address			**Telephone Number**

Child/Dependent 2 – this individual is:

Last Name	First Name	Middle Name

☐ This individual is deceased
☐ I do not know if this individual is living
☐ This individual is living but I am unable to locate this information
☐ This individual is living and the information is below

Mailing Address			Apartment/Suite Number
City	State/Province	Zip/Postal Code	Country (if not the U.S.)
Email Address			Telephone Number

G. Are there any other potential beneficiaries or persons who may have an interest in the claim?

○ Yes ○ No

If **Yes**, complete the information below:

Last Name	First Name	Middle Name

Mailing Address			Apartment/Suite Number
City	State/Province	Zip/Postal Code	Country (if not the U.S.)
Email Address			Telephone Number

PRESENCE AT THE PENTAGON OR SHANKSVILLE, PA SITE

If the victim was present at both the Pentagon and Shanksville, PA sites, provide two complete copies of this appendix with your claim form, completing one for each site.

1. **Select the site at which the victim was present at some point during the time period beginning September 11, 2001 through May 30, 2002.**

   ☐ Pentagon

   ☐ Shanksville, PA

2. **Why was the victim present at the site during the time period beginning September 11, 2001 through May 30, 2002?**

   ☐ Part of the rescue, recovery, and debris clean-up

   ☐ Pentagon Only: Through his or her ordinary employment as a non-responder

3. **What is the name of the entity the victim was affiliated with when present during the time period beginning September 11, 2001 through May 30, 2002?**

4. **Indicate below if the victim was an employee, a contractor, or a volunteer with the entity named in Question 3:**

   ☐ **Employee**

   Provide the employer's address, including a name and contact information for any known supervisors/points of contact:

   Employer Address:

   Supervisor Name:
   Contact Details:

   Is this employer still in business? ○ Yes ○ No ○ Do Not Know

   ☐ **Contractor**

   Provide the employer's name and address, including contact information for any known supervisors/points of contact:

   Employer Address:

   Supervisor Name:
   Contact Details:

   Is this employer still in business? ○ Yes ○ No ○ Do Not Know

   ☐ **Volunteer**

5. **If the victim was a member of an employee union when working or volunteering at the site, identify the union:**

6. **Identify the dates (or range of dates) on which the victim was at the site from September 11, 2001 through May 30, 2002:**

7. **Approximately how many hours per day was the victim present on the dates listed above?**

8. **Was the victim present at the site during the time period beginning September 11, 2001 through May 30, 2002 in a capacity other than those listed in the previous questions?**

   ○ Yes ○ No

   If **Yes**, explain what the victim was doing at the site:

If the victim was present at both the Pentagon and Shanksville, PA sites, provide two complete copies of this appendix with your claim form, completing one for each site.

PRIVATE PHYSICIAN PACKET – NYC EXPOSURE ZONE

You should only complete the Private Physician forms if you meet one of the following criteria:

- You received specific direction from the VCF to compete the forms; or
- You are filing a claim for a deceased individual who was not certified for treatment by the WTC Health Program for the claimed condition; or
- You are a foreign resident, living outside the continental United States, who has not been certified for treatment by the WTC Health Program for the claimed condition; or
- You were previously deemed eligible for compensation from the VCF based on a certified condition, or you are filing a claim for a deceased individual who was previously deemed eligible for compensation from the VCF based on a certified condition, and you are now seeking to add a non-certified cancer as a claimed condition; or
- You were present at the Pentagon or the Shanksville, PA site as a non-responder and, therefore, you do not qualify for certification by the WTC Health Program; or
- You are not able to go to a WTC Health Program center (either in the New York City metropolitan area or through the Nationwide Provider Network) to have your condition evaluated and certified for treatment without suffering significant hardship. If you believe that you will suffer significant hardship in seeking certification by the WTC Health Program, you should upload a statement or letter to the claim explaining the circumstances and why you should be considered for the Private Physician process **and** call the VCF Helpline to alert us to the request.

**** * If you do not meet the criteria above, you should not complete the Private Physician forms. * ****

Complete this form if the victim meets the criteria for the VCF Private Physician process and was present in the NYC disaster area. **If you do not meet the criteria for the Private Physician process and you submit these forms, the VCF will not review them when evaluating your claim.**

The NYC disaster area as defined in the Zadroga Act for purposes of evaluating eligibility of your claimed condition under the WTC Health Program consists of the area of Manhattan that is south of Houston Street; AND any block in Brooklyn that is wholly or partially contained within a 1.5-mile radius of the former World Trade Center site; AND any area related to, or along, routes of debris removal, such as barges and Fresh Kills. See http://www.cdc.gov/wtc/define.html.

If the victim is claiming ONLY traumatic injuries or musculoskeletal disorders (e.g., low back pain, carpal tunnel syndrome, etc.) do not complete this form. In order for these conditions to be found eligible, the claimant must show where and when the injury occurred and its relationship to the events of 9/11.

1. Victim's Name:

First	Middle	Last

2. Provide the dates the victim was present in the NYC disaster area between September 11, 2001 – July 31, 2002.

Start Date (mm/dd/yyyy)

Finish Date (mm/dd/yyyy)

Comments (optional)

3. Was the victim in the NYC disaster area at any time ON September 11, 2001?

○ Yes ○ No

If **Yes,** Check the option that provides the most relevant description:

- ☐ Directly in the cloud of dust (or "blackout") from the collapse of the WTC buildings
- ☐ Exposed to significant amounts of dust but not directly in the cloud of dust from the collapse of the WTC buildings
- ☐ Exposed to some dust but not in the cloud of dust from the collapse of the WTC buildings
- ☐ Not exposed to dust and not in the cloud of dust from the collapse of the WTC buildings
- ☐ Do Not Know

4. If the victim was in the NYC disaster area on September 11, 2001, please identify the victim's specific location and activity on September 11, 2001:

5. Indicate the estimated total duration of exposure for each of the relevant exposure timeframes listed in the table below. ***Total Duration of Exposure is the <u>total number of hours</u> that the victim performed rescue, recovery, demolition, debris removal, and related support services, or lived, worked, went to school, commuted or visited while within the NYC disaster area.***

Time Period during which Exposure Occurred	Estimated Total Duration of Exposure	Location in the NYC Disaster Area
September 11 – 14, 2001		
September 15 – 30, 2001		
October 1, 2001 – July 31, 2002		

For each timeframe for which you listed estimated hours, you must provide documents that confirm the dates and hours the victim was in those areas. The VCF will accept many different types of documents that ***specifically confirm the estimated hours the victim was present*** in the NYC disaster area. If the proof of presence documentation you submitted with your claim form supports the estimated hours of exposure listed in the table above, you do not need to submit additional documentation. If the proof of presence documentation you submitted does <u>not</u> support the estimated hours of exposure listed in the table above, you must submit additional documentation confirming the dates and hours the victim was in the NYC disaster area. This may include employer records, official personnel rosters, or two sworn affidavits from people who personally saw or supervised the victim during the relevant timeframes.

6. Indicate the victim's relative amount of dust/fume/smoke exposure while in the NYC disaster area for each time period listed in the table below. Check the most prevalent layer for each time period.

Time Period during which Exposure Occurred	**Heavy visible layer** of dust and/or smell of WTC smoke	**Light visible layer** of dust and/or smell of WTC smoke	**No visible layer** of dust or smell of WTC smoke
September 11 – 14, 2001	☐	☐	☐
September 15 – 30, 2001	☐	☐	☐
October 1, 2001 – July 31, 2002	☐	☐	☐

For the purposes of completing questions 7 and 8, please use the following definitions:

- A **Responder** is a worker or volunteer who provided rescue, recovery, demolition, debris removal, and related support services in the aftermath of the September 11, 2001 attacks on the World Trade Center.
- A **Non-Responder** is a person who was present in the "NYC disaster area" in the aftermath of the September 11, 2001, terrorist attacks on the World Trade Center as a result of their work, residence, or attendance at school, childcare, or adult daycare.

7. If the victim was a responder, indicate in the table below the location(s) where the victim performed the response activities and the jobs/tasks performed.

Location of response activities (check all that apply):

- ☐ On the pile/in the pit
- ☐ Adjacent to the pile/pit
- ☐ Landfill
- ☐ Other Location (specify):
- ☐ Barges/loading piers
- ☐ Elsewhere south of Canal Street
- ☐ Do Not Know

Job/task (check all that apply):

- ☐ Body bag work
- ☐ Bucket brigade
- ☐ Cable installation/repair/splicing (excluding work performed in manholes)
- ☐ Cable installation/repair/splicing (including work performed in manholes)
- ☐ Canteen services
- ☐ Counselor
- ☐ Custodian
- ☐ Dog Handler
- ☐ Dust suppression
- ☐ Other - specify:
- ☐ EMT
- ☐ Escorting
- ☐ Excavation/confined space work
- ☐ Firefighter
- ☐ Industrial hygiene
- ☐ Morgue work
- ☐ Perimeter security
- ☐ Sanitation worker
- ☐ Search and rescue
- ☐ Sifting (excluding conveyor belt)
- ☐ Sifting (including conveyor belt)
- ☐ Torch cutting or burning
- ☐ Towing
- ☐ Truck loading/unloading
- ☐ Truck routing
- ☐ Work with concrete

8. If the victim's activities were not as a responder, indicate the location(s) where the victim lived, worked, went to school, commuted or visited the NYC disaster area. Check all that apply.

- ☐ Worker in one of the WTC towers
- ☐ Worker in surrounding offices, stores, restaurants, or other workplace
- ☐ Patron of surrounding stores, offices, or restaurants
- ☐ Student or staff at school or preschool
- ☐ Adult in daycare or staff at a daycare center
- ☐ At place of residence – provide address:
- ☐ In Transit or Other Location – specify:

PRIVATE PHYSICIAN PACKET – PENTAGON AND SHANKSVILLE, PA DISASTER AREAS

You should only complete the Private Physician forms if you meet one of the following criteria:

- You received specific direction from the VCF to compete the forms; or
- You are filing a claim for a deceased individual who was not certified for treatment by the WTC Health Program for the claimed condition; or
- You are a foreign resident, living outside the continental United States, who has not been certified for treatment by the WTC Health Program for the claimed condition; or
- You were previously deemed eligible for compensation from the VCF based on a certified condition, or you are filing a claim for a deceased individual who was previously deemed eligible for compensation from the VCF based on a certified condition, and you are now seeking to add a non-certified cancer as a claimed condition; or
- You were present at the Pentagon or the Shanksville, PA site as a non-responder and, therefore, you do not qualify for certification by the WTC Health Program; or
- You are not able to go to a WTC Health Program center (either in the New York City metropolitan area or through the Nationwide Provider Network) to have your condition evaluated and certified for treatment without suffering significant hardship. If you believe that you will suffer significant hardship in seeking certification by the WTC Health Program, you should upload a statement or letter to the claim explaining the circumstances and why you should be considered for the Private Physician process **and** call the VCF Helpline to alert us to the request.

**** * If you do not meet the criteria above, you should not complete the Private Physician forms. * ****

Complete this form if the victim meets the criteria for the VCF Private Physician process and was present at the Pentagon or Shanksville, PA sites. **If you do not meet the criteria for the Private Physician process and you submit these forms, the VCF will not review them when evaluating your claim.**

Victim's Name:

First	Middle	Last

1. Indicate the site where the victim was located:

☐ Pentagon
☐ Shanksville, PA

Specify the exact Location:

2. Provide the dates the victim was present in the disaster area between September 11, 2001 – July 31, 2002.

Start Date (mm/dd/yyyy)

Finish Date (mm/dd/yyyy)

Comments (optional)

3. Indicate the estimated total duration of exposure for each of the relevant exposure timeframes listed in the table below. *Total Duration of Exposure is the <u>total number of hours</u> that the victim was within the disaster area for each timeframe.* Only fill out <u>one</u> table based on where the victim was present:

For Pentagon:

Time Period during which Exposure Occurred	Estimated Total Duration of Exposure	Location During Relevant Timeframe
September 11 – 12, 2001		
September 13 – November 19, 2001		

For Shanksville:

Time Period during which Exposure Occurred	Estimated Total Duration of Exposure	Location During Relevant Timeframe
September 11 – 12, 2001		
September 13 – October 3, 2001		

For each timeframe for which you listed estimated hours, you must provide documents that confirm the dates and hours the victim was in those areas. The VCF will accept many different types of documents that ***specifically confirm the estimated hours the victim was present*** in the designated area. If the proof of presence documentation you submitted with your claim form supports the estimated hours of exposure listed in the table above, you do not need to submit additional documentation. If the proof of presence documentation you submitted does <u>not</u> support the estimated hours of exposure listed in the table above, you must submit additional documentation confirming the dates and hours the victim was in the area. This may include employer records, official personnel rosters, or two sworn affidavits from people who personally saw or supervised the victim during the relevant timeframes

4. Indicate the victim's relative amount of dust/fume/smoke exposure that describes the <u>most prevalent</u> layer for each time period:

Time Period during which Exposure Occurred	**Heavy visible layer** of dust and/or caught in heavy smoke plume from crash	**Light visible layer** of dust and/or smell of smoke or chemicals	**No visible layer** of dust and/or smell of smoke or chemicals
September 11 – 12, 2001	☐	☐	☐
September 13 – November 19, 2001 (Pentagon site)	☐	☐	☐
September 13 – October 3, 2001 (Shanksville site)	☐	☐	☐

5. **Describe the activities the victim was engaged in during the relevant timeframe, noting the approximate locations that these activities occurred:**

6. **Describe the type of exposure hazards that you believe were encountered during these activities:**

7. **Describe the adequacy of the Personal Protective Equipment ("PPE") that was utilized, noting any breaches of this PPE that may have occurred:**

8. **Optional – use this space to provide additional comments for consideration:**