Certification Regarding Medical Records
Countermeasure Injury Compensation Program (CICP)

CICP Case Number: _____

I, _____ (name), certify the following:

I have filed a Request for Benefits under the CICP, either for myself, or as the representative of _____ (name).

I am (please check all that apply):

- ☐ The injured countermeasure recipient.
- ☐ The personal or legal representative(s) of the injured countermeasure recipient.
- ☐ The executor/administrator(s) of the estate of the deceased injured countermeasure recipient.
- ☐ The personal or legal representative(s) of the executor/administrator(s) of the estate of the deceased injured countermeasure recipient.
- ☐ The survivor(s) of the deceased injured countermeasure recipient.
- ☐ The personal or legal representative(s) of the survivor(s) of the deceased injured countermeasure recipient.
- ☐ The legal guardian(s) of the deceased injured countermeasure recipient who was a minor at the time of death.
- ☐ The personal or legal representative(s) of the legal guardian(s) of the deceased injured countermeasure recipient who was a minor at the time of death.

I obtained medical records from the injured countermeasure recipient's healthcare providers. The medical records I am submitting to the CICP are the records that I received from the injured countermeasure recipient's health care providers. I am submitting the medical records I received in their entirety. I have not altered, added, deleted, or changed the records in any way.

I understand that any person who knowingly falsifies, conceals, or covers up a material fact, makes a materially false, fictitious, or fraudulent statement or representation, or makes or uses a false writing or document knowing it contains a materially false, fictitious or fraudulent statement or entry to obtain compensation under the CICP, or who knowingly accepts compensation to which that person is not entitled, may be subject to civil, administrative, and felony criminal penalties, which may be punishable by a fine, imprisonment or both.

I have read and understand the above statements and certify under the penalty of perjury that they are true and correct.

Signature _____ Date_____

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PRIVACY ACT STATEMENT

Section 319F-4 of the Public Health Service Act (PHS Act), Public Law 109-148 (42 U.S.C. 247d-6e), and the Debt Collection Improvement Act of 1996 authorize collection of this information. It will be used to determine your eligibility to receive benefits. This information will be disclosed to the U.S. Department of Health and Human Services and its consultants; and Federal, State, or local law enforcement agencies, if the Government becomes aware of a possible violation of civil or criminal law; and for certain medical research purposes when consistent with the purposes for which the Program was formed, i.e., to make determinations concerning alleged covered countermeasure injury associations and to provide compensation to individuals injured by covered countermeasures. Furnishing the information on this Form, including the social security number, is voluntary, but failure to do so may delay or prevent the receipt of a payment. The information collected will be maintained confidentially pursuant to the Privacy Act, 5 USC Section 552a, as amended.

PUBLIC BURDEN STATEMENT

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0334. Public reporting burden for this collection of information is estimated to average 5 hours per respondent annually, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857