

## Countermeasures Injury Compensation Program (CICP)

### Certification of Status: Lost Employment Income

Case Number: \_\_\_\_\_

This Certification will assist the Countermeasures Injury Compensation Program (CICP) in determining benefits. Please complete the statement below that applies to your case, and print and sign your name below. For guidance on which statement to complete, see Section II of Attachment 1- "Documentation Required to Reimburse or Pay for Medical Expenses and/or Lost Employment Income."

#### Option 1

I certify that \_\_\_\_\_ is **not** requesting lost employment  
(injured countermeasure recipient's name)

income for injuries detailed in the CICP decision letter dated [ ].

#### Option 2

I certify that \_\_\_\_\_ is requesting lost employment income  
(injured countermeasure recipient's name)

for injuries detailed in the CICP decision letter dated [ ] and **was not** covered by a third-party

payer of lost employment income during the period of \_\_\_\_\_ to  
(date of no coverage)

\_\_\_\_\_  
(date no coverage ended or the present)

#### Option 3

I certify that \_\_\_\_\_ is requesting lost employment income  
(injured countermeasure recipient's name)

for injuries detailed in the CICP decision letter dated [ ] and **was** covered by a

third-party payer of lost employment income during the period of

\_\_\_\_\_ to \_\_\_\_\_  
(date of coverage) (date coverage ended or the present)

*By signing this form, I hereby certify that the information provided in this Certification is true and accurate to the best of my knowledge. Further, I understand that false statements or claims made in connection with this Certification, including subsequent information and documentation submitted in connection with this Certification, may result in any remedy, including civil remedies, available by law to the United States. I will provide updated information (including, but not limited to medical records, employment income records, and change of address) until the Program has made its final benefits decision.*

\_\_\_\_\_  
Name of Requester (Please Print)

\_\_\_\_\_  
Name of Representative (if applicable)

\_\_\_\_\_  
Signature of Requester or Representative

\_\_\_\_\_  
Date

Public Burden Statement: The purpose of this data collection is to gather information to allow the Secretary of Health and Human Services to determine if requesters are eligible for Countermeasure Injury Compensation Program (CICP) benefits. Requesters (or their representatives) must submit appropriate documentation forms and relevant medical records as specified in Section 42 CFR 110.50-110.53 to the CICP. 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 information collection is 0915-0334 and it is valid until XX/XX/202X. This information collection is required to obtain or retain a benefit (42 CFR Part 110). Access to these records is strictly limited to authorized users who are aware of their responsibilities under the Privacy Act and who are required to maintain Privacy Act safeguards with respect to such records. The System of Records Notice for Injury Compensation Programs, HHS/HRSA/HSB, System No. 09-15-0056, identifies authorized users. Public reporting burden for this collection of information is estimated to average 3.5 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or [paperwork@hrsa.gov](mailto:paperwork@hrsa.gov).