OMB Number: 0915-0334
Expiration date: 4/30/2026

**Countermeasures Injury Compensation Program (CICP)**

**Certification of Status for Administrators of the Estate: 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."

The CICP requests that you send all documentation within 60 days of the date of this letter. Please submit the requested form online at **injurycompensation.hrsa.gov (preferred)**. If you cannot submit the form electronically, please send it to the following address:

Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, 8W-25A
Rockville, MD 20857

If you have questions, please call 1-855-266-2427, email CICPBenefits@hrsa.gov, or mail them to the address above.

**Option 1**

I certify that_____ is ***not*** requesting payment for lost
(name of the administrator of the estate of deceased injured countermeasure recipient)

employment income for injuries detailed in [Deceased Countermeasure Recipient]'s CICP

decision letter dated [insert date].

**Option 2**

I certify that _____ is requesting payment for lost employment
(name of the administrator of the estate of deceased injured countermeasure recipient)

income for injuries detailed in [Deceased Countermeasure Recipient]'s CICP decision letter dated

[insert date] 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 payment for lost employment
(name of the administrator of the estate of deceased injured countermeasure recipient)

OMB Number: 0915-0334
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income for injuries detailed in [Deceased Injured Countermeasure Recipient]'s CICP decision letter

dated [insert date] 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 Deceased Injured Countermeasure Recipient
(Please print)

_____
Name of the administrator of the estate of the Deceased Injured Countermeasure Recipient (Please print)

_____ _____
Signature of the administrator of the estate of deceased injured countermeasure recipient Date