Certification Regarding Medical Records
Countermeasures 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______________________

Please submit this 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