



Part 3: RELATIONSHIP TO THE PERSON WHO BECAME ILL.

Please indicate your relationship to the person who became ill and follow the appropriate directions.

☐ **Self** (go to Part 4 on page 3)

☐ **Parent** (go to Part 7 on page 6)

☐ **Spouse** (go to Part 5 on page 3)

☐ **Grandchild** (go to Part 7 on 6)

☐ **Child** (go to Part 6 on page 4)

☐ **Grandparent** (go to Part 7 on page 6)

Part 4: SELF-FILERS, individuals who became ill and are filing for themselves.

Required documents: Unless you have filed electronically, you will need to provide certified or original copies of the documents requested in this claim form to support this claim (photocopies, even if notarized, are not sufficient unless certified by the issuing institution).

☐ Birth certificate: yours.

☐ Marriage certificate(s): documenting *all* changes of name, if applicable.

If you are a SELF-FILER, please continue to Part 8 of the claim form. You should NOT fill out Parts 5, 6, and 7.

Part 5: SURVIVING SPOUSE, the individual who was married to the person who became ill for at least one year prior to his or her death.

Please answer the following questions:

Is the person identified in Part 2 deceased? If "NO," you are not eligible to file this claim.

YES ☐ **NO** ☐

Were you married to the claimant, the person who became ill, for at least one year immediately prior to his or her death? If "NO," you are not eligible to file this claim.

YES ☐ **NO** ☐

Was the person who became ill married to anyone else BEFORE he or she married you?

YES ☐ **NO** ☐

If "YES," please list the name of each previous spouse and the dates which the marriage began and ended.

Have you ever been married to anyone else other than the person who became ill?

YES ☐ **NO** ☐

If “YES,” please list the name of each spouse and the dates which the marriage began and ended.

Required documents: Unless you have filed electronically, A SURVIVING SPOUSE must provide certified or original copies of the documents requested in this claim form to process this claim (photocopies, even if notarized, are not sufficient unless certified by the issuing institution).

- ☐ Birth certificate: of the person who became ill.
- ☐ Death certificate: of the person who became ill.
- ☐ Marriage certificate: documenting your marriage to the person who became ill.
- ☐ Marriage certificate(s): documenting any previous marriages of the person who became ill, if applicable.
- ☐ Divorce decree(s) or death certificate(s): documenting the end of any previous marriages of the person who became ill, if applicable.
- ☐ Birth certificate: yours.
- ☐ Marriage certificate(s): documenting all of your other marriages, if applicable.
- ☐ Divorce decree(s) or death certificate(s): documenting the end of any of your marriages before your marriage to the claimant.

If you are a SURVIVING SPOUSE, please continue to Part 8 of the claim form. You should NOT fill out Parts 4, 6, or 7.

Part 6: SURVIVING CHILD, an individual who was a natural, adopted, or step-child of the person who became ill.

Please answer the following questions:

Is the person identified in Part 2 (the person who became ill) deceased? If “NO,” you are not eligible to file this claim.

YES ☐ NO ☐

Was the person who became ill ever married?

YES ☐ NO ☐

If “YES,” please list the name of each spouse and the dates which the marriage began and ended.

Are you a natural child, adopted child, or step-child of the decedent?

NATURAL ☐ **ADOPTED CHILD** ☐ **STEP-CHILD** ☐

Did the decedent have any other natural, adopted, or step-children? **YES** ☐ **NO** ☐

If so, list the name of each child, date and place of birth, phone number, and current address or date and place of death.

1) Name: _____ Date and place of birth: _____

Date and place of death, if applicable: _____

Current address, if applicable: _____

Phone number, if applicable: _____

2) Name: _____ Date and place of birth: _____

Date and place of death, if applicable: _____

Current address, if applicable: _____

Phone number, if applicable: _____

3) Name: _____ Date and place of birth: _____

Date and place of death, if applicable: _____

Current address, if applicable: _____

Phone number, if applicable: _____

If there are more children of the claimant, please use the back of this page or attach another sheet to provide the information requested above and check here: ☐

Required documents: Unless you have filed electronically, A SURVIVING CHILD must provide certified or original copies of the documents requested in this claim form to process this claim (photocopies, even if notarized, are not sufficient unless certified by the issuing institution).

☐ Birth certificate: of the person who became ill.

☐ Death certificate: of the person who became ill.

☐ Marriage certificate(s): of the person who became ill.

☐ Divorce decree(s) or death certificate(s): documenting that all marriages of the person who became ill have ended.

☐ Birth certificate or papers of adoption: yours.

☐ Marriage certificate(s): documenting all of your name changes, if applicable.

☐ If you are a step-child of the person who became ill, send proof that their spouse was one of your natural parents and any records which show that you lived with the person who became ill in a regular parent-child relationship (for example, school records).

☐ Death certificates: of any siblings that have passed away.

In addition, the RECA Program will need identification documents for **ALL** other eligible surviving children of the person who became ill including:

- ☐ Birth certificate for each eligible surviving beneficiary
- ☐ Marriage certificate(s) for each eligible surviving beneficiary, where a change of name has occurred.

- ☐ **If you would like to expedite your claim, please have each eligible surviving beneficiary review the claim form and sign their name on the page titled Attached Signatures of Eligible Surviving Beneficiaries.**

If you are a SURVIVING CHILD, please continue to Part 8 of the claim form. You should NOT fill out Parts 4, 5, or 7.

Part 7: PARENTS, GRANDCHILDREN or GRANDPARENTS.

If you are filing as a PARENT, a GRANDCHILD, or a GRANDPARENT of the person who became ill, a member of the RECA Program staff will contact you to provide further assistance in establishing your relationship to the person who became ill.

What is your relationship to the person who became ill?

PARENT ☐ **GRANDCHILD** ☐ **GRANDPARENT** ☐

At this time, you will need to submit the following certified or original documents:

- ☐ Birth certificate: of the person who became ill.
- ☐ Death certificate: of the person who became ill.
- ☐ Marriage certificate(s): of the person who became ill.
- ☐ Divorce decree(s) or death certificate(s): documenting that any and all marriages of the person who became ill have ended.
- ☐ Death certificate(s): of any deceased children of the person who became ill.
- ☐ Birth certificate or papers of adoption: yours.
- ☐ Marriage certificate(s): documenting all of your name changes, if applicable.

Part 8: EMPLOYMENT HISTORY. This section concerns information about the employment history of the claimant. To be eligible for compensation, the claimant must have been employed as a uranium miner, uranium miller, uranium ore transporter, core driller, or mine remediation worker in the states of Colorado, New Mexico, Arizona, Wyoming, South Dakota, Washington, Utah, Idaho, North Dakota for at least one year during the period beginning January 1, 1941, and ending December 31, 1990. Alternatively, individuals who worked in a uranium mine located in the above states may establish eligibility through exposure to 40 or more working level months (WLMs) of radiation, or exposures that when combined with periods of employment as a miller, ore transporter, or core driller were comparable to 1 year of employment in a covered occupation.

Provide as much work history information as possible concerning the person who became ill. Begin with the earliest period of employment and continue chronologically until the last period of employment. Please provide any records you now have which show that the claimant worked in the positions listed on the chart. Any records provided must be original or certified copies, unless you have filed this claim electronically.

Employer 1:	Starting date:	End Date:
Location of Work: (state or region)	Name of Mine / Mill: (if applicable)	
Type of Employment (check all that apply): ☐ Uranium Mining ☐ Uranium Milling ☐ Uranium or Vanadium-Uranium Ore Transporting ☐ Uranium Core Drilling ☐ Mine / Mill Remediation		
Description of duties:		

Employer 2:	Starting date:	End Date:
Location of Work: (state or region)	Name of Mine / Mill: (if applicable)	
Type of Employment (check all that apply): ☐ Uranium Mining ☐ Uranium Milling ☐ Uranium or Vanadium-Uranium Ore Transporting ☐ Uranium Core Drilling ☐ Mine / Mill Remediation		
Description of duties:		

Employer 3:	Starting date:	End Date:
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Location of Work: (state or region)	Name of Mine / Mill: (if applicable)
Type of Employment (check all that apply): ☐ Uranium Mining ☐ Uranium Milling ☐ Uranium or Vanadium-Uranium Ore Transporting ☐ Uranium Core Drilling ☐ Mine / Mill Remediation	
Description of duties:	

Employer 4:	Starting date:	End Date:
Location of Work: (state or region)	Name of Mine / Mill: (if applicable)	
Type of Employment (check all that apply): ☐ Uranium Mining ☐ Uranium Milling ☐ Uranium or Vanadium-Uranium Ore Transporting ☐ Uranium Core Drilling ☐ Mine / Mill Remediation		
Description of duties:		

If there are more periods of employment you would like to identify, please attach another sheet to provide the information requested above and check here: ☐

Was the person who became ill employed in any other kind of work in the uranium industry between 1942 and 1971, besides the roles listed above?

YES [] NO []

If YES, please describe:

Did the person who became ill participate in any of the following studies? (Please check any that apply):

- ☐ Public Health Service Study of Uranium Miners/National Institute for Occupational Safety and Health
- ☐ St. Mary's Hospital Study of Uranium Miners
- ☐ University of New Mexico School of Medicine/Tumor Registry Study of Uranium Miners

Part 9: COMPENSABLE DISEASES.

Examine the list of compensable diseases. Place a check next to the disease(s) that the person who became ill developed.

If the claimant did not become ill with one of the listed diseases, you are not eligible for compensation.

- | | |
|--|---|
| ☐ lung cancer | ☐ pneumoconiosis |
| ☐ pulmonary fibrosis, fibrosis of the lung | ☐ renal (kidney) cancer |
| ☐ cor pulmonale related to fibrosis of the lung | ☐ any other chronic renal disease including nephritis and kidney tubal tissue injury |
| ☐ silicosis | |

Part 10: PROOF OF COMPENSABLE DISEASE.

This part concerns records which can prove that the uranium worker became ill with lung cancer, a nonmalignant respiratory disease, renal cancer, or chronic renal disease.

In order for you to establish that the uranium worker contracted a compensable disease, you will need to submit certain medical documents that show a diagnosis of a compensable disease. For a complete list of the specific documents accepted for each illness, consult the Medical Records Attachment at the end of this form. To certify the record, ask your source of the record (hospital or doctor's office) to attach a cover letter to the record stating, "the attached medical records consisting of [# of] pages pertaining to [the person who became ill] are true and accurate copies of records kept in our files."

- ☐ I HAVE SUBMITTED CERTIFIED MEDICAL RECORDS SHOWING A DIAGNOSIS OF A COMPENSABLE DISEASE

Have you received assistance from a Radiation Exposure Screening and Education Program (RESEP) clinic?

YES ☐ NO ☐

Please specify which clinic assisted you (if you do not know the name of the clinic, please state the location of the clinic): _____

Some states have cancer registries which maintain records of individuals who have had cancer diagnosed in that state. *If the person who became ill was diagnosed with lung cancer or renal cancer, you may ask the RECA Program to contact a state cancer registry on your behalf. To do so, please indicate below and complete the authorization to release medical information attached to this claim form.*

☐ I WANT THE RECA PROGRAM TO CONTACT A STATE CANCER REGISTRY AND I HAVE SIGNED THE AUTHORIZATION TO RELEASE MEDICAL INFORMATION.

Part 11: PREVIOUS PAYMENTS OF MONEY.

Have you or anyone else received any payment of money pursuant to final award or settlement on a claim (other than a claim for worker's compensation) against any person (including a corporation), that is based on the illness for which this claim is submitted? Please check "YES" if you have already received an award under RECA on behalf of the claimant identified in this application, even if the payment was based on a different illness than the one claimed here.

YES ☐ NO ☐

If you checked "YES," please attach a statement identifying the date, amount, and person or organization from whom EACH AND EVERY payment of money was received, and explain the circumstances surrounding the payment.

Have you or anyone else filed a claim under the Department of Labor's Energy Employees Occupational Illness Compensation Program Act (EEOICPA)?

YES ☐ NO ☐

Part 12: ATTORNEY REPRESENTATION.

Have you hired an attorney to represent you for the purpose of filing this claim?

YES ☐ **NO** ☐

PLEASE NOTE: You are not required to hire an attorney to file this claim. If you wish to be represented by an attorney, you are responsible for making arrangements for that attorney to be paid. Under the Act, notwithstanding any contract, an attorney may not receive more than 2 percent for the filing of an initial claim; and 10 percent with respect to any claim in which a representative has made a contract for services before July 10, 2000; or a resubmission of a denied claim. Attorneys are permitted to recover costs and expenses regardless of whether the claim is approved or denied. Attorneys representing claimants are required to submit a signed representation agreement, retainer agreement, fee agreement, or contract documenting the attorney's authorization to represent the claimant or beneficiary. The document must acknowledge that the Act's fee limitations are satisfied. The attorney must also submit a statement of active membership and good standing of the bar of the highest court of a state.

If you choose to hire an attorney, the RECA Program will correspond and communicate only with your attorney on all matters related to your claim.

If “YES,” please indicate your attorney’s name, firm, address and phone number here:

First Name[illegible]

Last Name

[illegible]

Firm

[illegible]

Mailing Address

[illegible]

City

[illegible]

State

--	--

Zip Code

--	--	--	--	--

Phone Number**Fax Number**

Phone Number (day)

			-				-				
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Phone Number (evening)

			-				-				
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E-mail Address

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Part 15: SIGNATURE.

We cannot process this claim form if you do not sign this page.

I declare under penalty of perjury that the information in this claim is true, correct, and complete to the best of my knowledge and belief. I acknowledge that any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided under RECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may be punished by a fine or imprisonment or both.

I authorize the Department of Justice to share information provided in my claim with the Department of Labor, Office of Workers Compensation Programs. I further authorize any physician or hospital (or any other person, institution, corporation, or government agency, including the Social Security Administration) to furnish any desired information to the U.S. Department of Justice, Civil Division, for purposes of determining entitlement under RECA.

X_____

**Signature of person identified in Part 1
or Legal Guardian identified in Part 14**

Date

Civil Penalty for Presenting a Fraudulent Claim or Making False Statements or Using False Records

The declarant shall forfeit and pay to the United States the sum of \$10,000 plus treble the amount of damages sustained by the United States. (See 31 U.S.C. Section 3729).

Criminal Penalty for Presenting a Fraudulent Claim or Making False Statements Fine and imprisonment for not more than 5 years. (See 18 U.S.C. Sections 287 and 1001).

You may file this form by mailing it to:

Radiation Exposure Compensation Program
U.S. Department of Justice
P.O. Box 146
Ben Franklin Station

Washington, DC 20044-0146

Privacy Act

The authority for the collection of this information is the Radiation Exposure Compensation Act, 42 U.S.C. § 2210 note, as amended by Pub. L. 119-21. The information you provide will be used to verify your identity, to verify your eligibility, and to verify any previous payments made in connection with the compensable disease you identified in Part 9 of the claim form. Some or all of the information you provide may be released to federal, state, and local government agencies or private organization for the purpose of confirming your identity, your eligibility, and any previous payments made in connection with the compensable disease. The information may also be released when otherwise authorized by statute or regulation. Disclosure of the information by you is voluntary; however, it may not be possible to process your claim without the information.

Reporting Burden

Public Reporting burden for this collection of information is estimated to average 2.5 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining that data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection of information, including suggestions for reducing this burden to: Radiation Exposure Compensation Program, U.S. Department of Justice, P.O. Box 146, Ben Franklin Station, Washington, DC 20044-0146.

**U.S. Department of Justice
Civil Division**

**AUTHORIZATION TO RELEASE
MEDICAL AND OTHER
INFORMATION FROM A
STATE CANCER REGISTRY**

STATE OF RESIDENCE AT TIME OF DIAGNOSIS: _____

I hereby authorize the cancer registry of the state identified above to release all medical and other information in its possession, custody, and control to representatives of the RECA Program, Department of Justice, relating to the individual whose name appears on line 1 of this form. This data is required to determine eligibility for compensation / benefits under the Radiation Exposure Compensation Act, 42 U.S.C. § 2210 note.

For the RECA Program to request medical information on your behalf, you must **SIGN THIS FORM.**

1. Name of the individual whose records are to be released (First, Middle, Maiden, Last, Other).

2. Social Security number of the individual whose records are to be released.

3. Birth date of the individual whose records are to be released.

—

4. Date of death of individual whose records are to be released, if applicable.

5. Name of the individual requesting release of information and relationship to the individual listed on line 1, if different.

X _____
Signature Date

Return this authorization with the claim form to:

Radiation Exposure Compensation Program
U. S. Department of Justice
P.O. Box 146
Ben Franklin Station
Washington, D.C. 20044-0146

U.S. Department of Justice

**Certification of Identity
and
Privacy Act Release**



RADIATION EXPOSURE COMPENSATION PROGRAM

CLAIM NO. _____

Privacy Act Statement. The purpose of this request is to ensure that records of individuals that are maintained by the Radiation Exposure Compensation Program of the U.S. Department of Justice are not wrongfully disseminated. In accordance with 28 CFR Section 16.41(d) personal data sufficient to identify the individuals submitting requests for information under the Privacy Act of 1974, 5 U.S.C. Section 552a, is required. False information on this form may subject the requester to criminal penalties under 18 U.S.C. Section 1001 and/or 5 U.S.C. Section 552a(i)(3).

Section 1: Certification of Identity. Please certify your identity. (The individual filing this claim.)

Full Name _____

Citizenship Status¹ _____ Social Security Number² _____

Current Address _____

Date of Birth _____ Place of Birth _____

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. Section 1001 by a fine of not more than \$10,000 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. 552a(i)(3) by a fine of not more than \$5,000.

Signature of individual filing this claim _____ Date _____

Section 2: Authorization to Release Information to Another Person (OPTIONAL)

If you would like the RECA Program staff to provide information to someone other than yourself about your claim, you must complete the section below.

Pursuant to 5 U.S.C. Section 552a(b), I authorize the U.S. Department of Justice to release any and all information relating to me and my claim to:

Print or Type Name _____ Relationship to Requester _____

Phone Number _____ Current Address _____

Signature of individual authorizing this release _____ Date _____

¹ Individuals submitting a request under the Privacy Act of 1974 must be either "a citizen of the United States or an alien lawfully admitted for permanent residence," pursuant to 5 U.S.C. Section 552a(a)(2). Requests will be processed as Freedom of Information Act requests pursuant to 5 U.S.C. Section 552, rather than Privacy Act requests, for individuals who are not United States citizens or aliens lawfully admitted for permanent residence.

² Providing your social security number is voluntary. You are asked to provide your social security number only to facilitate the identification of records relating to you. Without your social security number, the Department may be unable to locate any or all records pertaining to you.

RELEASE OF TRIBAL VITAL RECORDS

Please check the applicable box so that we may verify information through the tribe of which you are a member:

TO: THE NAVAJO NATION OFFICE OF VITAL RECORDS	☐
THE HOPI TRIBE ENROLLMENT DEPARTMENT	☐
SAN CARLOS APACHE TRIBAL ENROLLMENT OFFICE	☐
_____	☐
Other Tribal Records Office	

RE: AUTHORIZATION TO RELEASE INFORMATION

Claimant Name (Please print): _____

I hereby authorize the release of vital statistics information and/or records held by the _____ (name of tribal organization) to a representative of the Radiation Exposure Compensation Program of the United States Department of Justice pursuant

to 5 U.S.C. § 552a(b). This information is required to determine eligibility for compensation under the Radiation Exposure Compensation Act, 42 U.S.C. § 2210 note.

X_____

Signature, thumbprint or mark

Date

ATTACHED SIGNATURES OF ELIGIBLE SURVIVING BENEFICIARIES

If you are filing as a surviving child, you may expedite your claim by having each of your siblings review the claim and sign their name below. It is NOT necessary to have all surviving beneficiaries fill out this page, but the RECA Program will have to individually contact all eligible surviving beneficiaries who do not sign this page. Fill out this page ONLY if you are a surviving child of the person who became ill with a compensable disease. If you are a legal guardian signing on behalf of a surviving child, please indicate your status below.

By signing this page, you declare under penalty of perjury that the information in this claim is true, correct, and complete to the best of your knowledge and belief.

1. Name of Eligible Surviving Beneficiary (Please print): _____
Social Security number: _____ Date: _____
Signature of Eligible Surviving Beneficiary: _____
If represented by an attorney, please print his or her name here: _____
Phone number: _____

2. Name of Eligible Surviving Beneficiary (Please print): _____
Social Security number: _____ Date: _____
Signature of Eligible Surviving Beneficiary: _____
If represented by an attorney, please print his or her name here: _____
Phone number: _____

3. Name of Eligible Surviving Beneficiary (Please print): _____
Social Security number: _____ Date: _____
Signature of Eligible Surviving Beneficiary: _____
If represented by an attorney, please print his or her name here: _____
Phone number: _____

4. Name of Eligible Surviving Beneficiary (Please print): _____
Social Security number: _____ Date: _____
Signature of Eligible Surviving Beneficiary: _____
If represented by an attorney, please print his or her name here: _____
Phone number: _____

☐ *If there are other children filing on behalf of the claimant, please use the back of this page or attach another sheet with the information requested above and their signature and check here.*

Civil Penalty for Presenting a Fraudulent Claim or Making False Statements or Using False

Records: The declarant shall forfeit and pay to the United States the sum of \$10,000 plus treble the amount of damages sustained by the United States. (See 31 U.S.C. Section 3729).

Criminal Penalty for Presenting a Fraudulent Claim or Making False Statements: Fine and imprisonment for not more than 5 years. (See 18 U.S.C. Sections 287 and 1001).

Privacy Act

The authority for the collection of this information is the Radiation Exposure Compensation Act, 42 U.S.C. § 2210 note. The information you provide will be used to verify your identity, to verify your eligibility, and to verify any previous payments made in connection with the compensable disease you identified in Part 9 of the claim form. Some or all of the information you provide may be released to federal, state, and local government agencies or private organizations for the purpose of confirming your identity, your eligibility, and any previous payments made in connection with the compensable disease. The information may also be released when otherwise authorized by statute or regulation. Disclosure of the information by you is voluntary; however, it may not be possible to process your claim without the information.

MEDICAL RECORDS ATTACHMENT

Listed below are the records which the Radiation Exposure Compensation Program (RECA Program) will accept as proof that the person who became ill contracted **lung cancer, pulmonary fibrosis, fibrosis of the lung, cor pulmonale related to fibrosis of the lung, silicosis, pneumoconiosis, renal cancer, or chronic renal disease (including nephritis and kidney tubal tissue injury.)**

Tear off this attachment and take it to the doctor or hospital holding the records of the person who became ill any of the diseases bolded above

Show this list to the doctor or hospital and ask them to give you original or certified copies of the required medical documentation listed below. Submit the record(s) containing a diagnosis of the disease, if possible. Otherwise, send the records below that are available. Call the RECA Program if you have any questions at 1-800-729-7327.

(1) Lung Cancer

If the person with lung cancer is **deceased or living**, any of the following records may be submitted as proof of the disease:

- (A) Pathology report of tissue biopsy, including, but not limited to, specimens obtained by any of the following methods:
 - (i) surgical resection;
 - (ii) endoscopic, endobronchial, or transbronchial biopsy;
 - (iii) bronchial brushings and washings;
 - (iv) pleural fluid cytology;
 - (v) fine needle aspirate;
 - (vi) pleural biopsy; or
 - (vii) sputum cytology;
- (B) Autopsy report;
- (C) Bronchoscopy report;
- (D) One of the following summary medical reports:
 - (i) physician summary report;
 - (ii) hospital discharge summary report;
 - (iii) operative report;
 - (iv) radiation therapy summary report; or
 - (v) oncology summary or consultation report;
- (E) Reports of the radiographic studies, including:
 - (i) x-rays of the chest;
 - (ii) chest tomograms;
 - (iii) computer-assisted tomography (CT); or
 - (iv) magnetic resonance imaging (MRI); or
- (F) Death certificate, provided that it is signed by a physician at the time of death.

(2) Pulmonary Fibrosis, Fibrosis of the Lung, Silicosis, or Pneumoconiosis

If the person with pulmonary fibrosis, fibrosis of the lung, silicosis or pneumoconiosis is **deceased**, any of the following forms of medical documentation may be submitted:

- (A) Pathology report of tissue biopsy;
- (B) Autopsy report;
- (C) If an x-ray exists, the x-ray **and** interpretive reports of the x-ray by a maximum of two NIOSH certified "B" readers, classifying the existence of disease of category 1/0 or higher according to a 1989 report of the International Labor Office (known as the "ILO"), or subsequent revisions;
- (D) If no x-rays exist, an x-ray report;
- (E) Physician summary report;
- (F) Hospital discharge summary report;
- (G) Hospital admitting report;
- (H) Death certificate, provided that it is signed by a physician at the time of death; or
- (I) Documentation specified below in section (II)(B).

(2a) If the person with pulmonary fibrosis, fibrosis of the lung, silicosis, or pneumoconiosis is **living**, at a minimum the following medical records must be submitted:

I. Either:

- (A) An arterial blood gas study administered at rest in a sitting position, or an exercise arterial blood gas test; **or**
- (B) Written diagnosis by a physician as described in the regulations at § 79.51(s);

II. **And** one of the following:

- (A) A chest x-ray administered in accordance with standard techniques accompanied by interpretive reports of the x-ray by a maximum of two NIOSH certified "B" readers, classifying the existence of disease of category 1/0 or higher according to a 1989 report of the International Labor Office (known as the "ILO"), or subsequent revisions; **or**
- (B) High-resolution computed tomography scans (commonly known as "HRCT scans") including computer assisted tomography scans (commonly known as "CAT scans"), magnetic resonance imaging scans (commonly known as "MRI scans"), and positron emission tomography scans (commonly known as "PET scans") and interpretive reports of such scans; **or**
- (C) Pathology reports of tissue biopsies; **or**
- (D) Pulmonary function tests indicating restrictive lung function and consisting of three reproducible time/volume tracings recording the results of the forced expiratory volume in one second (FEV1) and the forced vital capacity (FVC) administered and reported in accordance with the Standardization of Spirometry–1994 Update by the American Thoracic Society, and reflecting values for FEV1 or FVC that are less than or equal to the lower limit of normal for an individual of the claimant's age, sex, height, and ethnicity.

(3) Cor Pulmonale Related to Fibrosis of the Lung

Please provide the same documentation as is required for proof of pulmonary fibrosis, fibrosis of the lung, silicosis, and pneumoconiosis in section (2) above. **Additionally**, whether the person with cor pulmonale related to fibrosis of the lung is **deceased or living**, provide one or more of the following medical records:

- (A) Right heart catheterization;
- (B) Cardiology summary or consultation report;
- (C) Electrocardiogram;
- (D) Echocardiogram;
- (E) Physician summary report;
- (F) Hospital discharge report;
- (G) Autopsy report;
- (H) Report of physical examination; or
- (I) Death certificate, provided that it is signed by a physician at the time of death.

(4) Renal Cancer

A claimant or beneficiary may submit any of the following forms of medical documentation:

- (A) Pathology report of tissue biopsy or resection;
- (B) Autopsy report;
- (C) One of the following summary medical reports:
 - (i) Physician summary report;
 - (ii) Hospital discharge summary report;
 - (iii) Operative report;
 - (iv) Radiotherapy summary report;
 - (v) Medical oncology summary or consultation report;
- (D) Report of one of the following radiology examinations:
 - (i) Computerized tomography (CT) scan;
 - (ii) Magnetic resonance imaging (MRI); or
- (E) Death certificate, provided that it is signed by a physician at the time of death.

(5) Chronic Renal Disease (including nephritis and kidney tubal tissue injury)

A claimant or beneficiary may submit any of the following forms of medical documentation:

- (A) Pathology report of tissue biopsy;
- (B) If laboratory or radiographic tests exist:
 - (i) Abnormal plasma creatinine values; and
 - (ii) Abnormal glomerular filtration rate (by either measured creatinine or iothalamate clearance or calculated by MDRD equation); and
 - (iii) Renal tubular dysfunction as evidenced by:
 - (a) glycosuria in the absence of diabetes mellitus;
 - (b) proteinuria without other known etiology; or
 - (c) hyperphosphaturia, aminoaciduria, B-2 microglobulinuria or alkaline phosphaturia or other marker of proximal tubular injury; or
 - (iv) Radiographic evidence of chronic renal disease;
- (C) Autopsy report;
- (D) Physician summary report;
- (E) Hospital discharge summary report;
- (F) Hospital admitting report; or
- (G) Death certificate, provided that it is signed by a physician at the time of death.