FORM 2

OMB Number: 0915-0334
Expiration date: 04/30/2026

Countermeasures Injury Compensation Program (CICP)
Request for Lost Employment Income
Requester Category: Injured Countermeasure Recipient (or Representative)

Case Number: _____ (starts with CICP)

This form ~~helps~~ is used to ~~the Countermeasures Injury Compensation Program (CICP)~~ determine your eligibility to receive **lost employment income benefits** and the amount of any such benefits. Please complete the statements that apply to your case. Then, print your name, sign the form, and submit it with the required documents as described in each section below.

A. Lost Employment Income

~~What~~ Are ~~are~~ you requesting lost employment income? (Check one)

☐ **YES** - I am requesting reimbursement o~~f~~ payment for **PAST and/or FUTURE** lost employment income where lost income was a result of a covered injury or its health complications for a specified period of time, greater than five days.

If you selected YES, please let us know if you had dependents at the time of the injury, by checking one of the following.

☐ ~~**YES,**~~ I had one or more dependents as indicated on my Federal tax return.

☐ ~~**NO,**~~ I di~~d~~ not have dependents.

*If you are requesting reimbursement or payment for lost employment income, please carefully read and complete the **Required Documents** included in this letter.*

☐ **NO** - I am **not** requesting reimbursement or payment for **PAST and/or FUTURE** lost employment income.

a. **If you checked YES:** Proceed to fill out B: Third-Party Payer Information.
b. If you checked NO: Skip to D: Final Attestation and Acknowledgment and sign the form and submit to CICP.

~~Complete all steps below.~~
~~a. **If you checked NO:** Skip to **Final Attestation and Acknowledgment** and sign the form and submit to CICP.~~
~~**If you checked YES:** Complete all steps below.~~

~~b.~~

B. Third-Party Payer Information

Check one:

~~☐ I certify **I do not have or know of any third-party payers** that did have paid or will may be obligated to pay for lost employment income or provide disability benefits.~~

☐ I certify that the table below includes all **third-party payers** that ~~did~~ have paid or ~~will~~ may be obligated to pay for lost employment income or provide disability benefits.

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If you do have third-party payers, complete the table below listing any and all third-party payers, which may include, but are not limited to, Workers' Compensation, ~~or~~ disability insurance, Uniform Services Retirement Board determinations, and Department of Veterans Affairs determinations.

If you have third-party payers, list them here:

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Third-Party Payer	Address/Phone Number	Dates of Coverage	Case Number

☐ I certify I **do not have or know of any third-party payers** that have paid or may be obligated to pay for lost employment income or provide disability benefits.

If you need additional space, you may attach a separate page

C. ~~Secondary~~ Payer of Last Resort Acknowledgement

Understanding CICP as ~~Secondary~~ Payer of Last Resort

☐ I understand benefits from the CICP are secondary to benefits ~~received or receivable~~paid or payable from third-party payers, and it may be possible that certain requesters deemed eligible will have **no eligible** lost employment income.

D. Final Attestation and Acknowledgment

By signing this form, I hereby certify that the information provided in this Request for Lost Employment Income ~~Certification~~ form is true and accurate to the best of my knowledge. Further, 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 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. ~~I am also signing with the understanding that the CICP is a secondary payer to benefits received or receivable from third-party payers, and it may be possible that certain requesters deemed eligible will have no eligible benefits.~~

_____
Name of Injured Countermeasure Recipient (Please print)

_____ _____
Signature of Requester 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 4/30/2026. 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 5.1 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. Please do not send documents related to an individual claim to paperwork@hrsa.gov.

LOST EMPLOYMENT INCOME REQUIRED DOCUMENTS

Name: _____ Case #: _____

PROOF OF NUMBER OF DAYS LOST

If you are requesting payment for lost employment income, ~~CICP must receive~~you must submit documents showing the number of days of lost employment income (unpaid days). Please submit documents showing the number of days (including partial days) of work missed. Examples may include:

- Time sheets showing pay periods
- Pay stubs showing pay periods
- Summary of how many total days missed in unpaid leave status (optional)

PROOF OF INCOME AT THE TIME OF THE INJURY

If you are requesting payment for lost employment income, ~~CICP must receive~~you must submit documents showing your gross income at the time of the covered injury. ~~Please submit~~Examples may include the following ~~information~~:

- Federal tax return (required if there are dependents)
- Pay stubs
- Time sheets

THIRD-PARTY PAYERS

If you have third-party payers, CICP must receive documents from the third-party payers that paid or ~~will~~ are obligated to pay for lost employment income, or provide . ~~This may include~~ disability~~,~~ and/~~or~~ ~~/~~retirement benefits, ~~or~~ such as workers' compensation, disability insurance programs, Uniformed Services Retirement Board determinations, and Department of Veterans Affairs determinations ~~payments~~, as follows.~~:~~

- Documents of payments made
- Documents of payments that will be made in the future
- A written summary of how many days of unpaid work were missed and what was or will be paid by third-party payers, if applicable

FUTURE LOST EMPLOYMENT INCOME

If you are requesting **future** lost employment income, CICP must receive documents about future payments made by third-party payers (above documents) as well as documentation from your provider stating how long you will not be able to work. This may include:

- Documents of disability status from the government or your employer
- Letter from the provider saying that you cannot work and for how long

How to send your forms and documents:

Option 1: (Preferred Method) Submit online:

1. Go to: https://cicpsubmit.hrsa.gov.
2. Upload your forms on the website.

Option 2: Send your forms via postal mail to:

Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, 14W-188~~W-25A~~
Rockville, MD 20857

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