

**ONSITE PARTICIPANT CLIENT INFORMATION FORM — PARENT FILER**

**Your Information:** (the person filing the claim)

1. First, Middle and Last Name: \_\_\_\_\_
2. Maiden Name (if applicable): \_\_\_\_\_ Any Prior Names: \_\_\_\_\_
3. Social Security Number: \_\_\_\_\_
4. Mailing Address: \_\_\_\_\_
5. Residence Address: \_\_\_\_\_
6. Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_
7. Email address: \_\_\_\_\_
8. Your Name at Birth: \_\_\_\_\_ Gender:  M  F
9. Date of Birth: \_\_\_\_\_ Place of birth: \_\_\_\_\_

**PLEASE PROVIDE YOUR BIRTH CERTIFICATE:**

(check if you would like our office to order) \*\*You will be responsible for the document fee plus an additional \$50 for any documents we order for you. We will send back all provided and ordered documents at the end of the claim.

10. Your Mother's full maiden name: \_\_\_\_\_
11. Your Father's name: \_\_\_\_\_
12. How many times have you been married? \_\_\_\_\_

**REQUIRED FOR FEMALES ONLY TO TRACK YOUR NAME CHANGE(S)**

(Below list the **date** and **place** of each marriage and the **name** of the spouse as well as the divorce date and place or if the marriage ended in death)

MARRIAGES: (mark box if provided)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**PLEASE PROVIDE ALL MARRIAGE CERTIFICATES.** These are provided to track all your name changes. We will send back all provided documents. For additional marriages please use the back of this page.

**Background Information about Your Parent/Victim:**

1. Your Parent's name at birth: \_\_\_\_\_ Gender:  M  F

2. Date of Birth: \_\_\_\_\_ Place of birth: \_\_\_\_\_

**PLEASE PROVIDE THE BIRTH CERTIFICATE OF YOUR PARENT**

(check box if you would like our office to order)

3. Date of Death: \_\_\_\_\_ Place of death: \_\_\_\_\_

**PLEASE PROVIDE THE DEATH CERTIFICATE OF YOUR PARENT**

(check box if you would like our office to order)

4. Social Security Number: \_\_\_\_\_

5. Parent's Mother's Full Maiden Name: \_\_\_\_\_

6. Parent's Father's Name: \_\_\_\_\_

7. Number of times your parent has been married? \_\_\_\_\_

(Below list the **date** and **place** of each marriage and the **name** of the spouse as well as the divorce date and place or if the marriage ended in death)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Background Information about Your Siblings**

1. Number of Brothers/Sisters (include natural born, adopted and step-siblings): \_\_\_\_\_

**List the names, addresses, and phone numbers of each of your siblings. PLEASE INCLUDE DATES OF BIRTH AND LOCATIONS OF BIRTH OF EACH SIBLING (if known). IF any of your siblings are deceased, please list their names and the date/location of their death)**

**SIBLINGS:**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

\*\* IF you have more than 5 siblings please mark here  and add them to the back of this page.

\*\* For females we will need their marriage certificates to track their name changes.

\*\* ALL SIBLINGS WILL NEED TO FILL OUT A SIBLING PACKET (3 forms)

## **Your Parent's Medical Information**

1. Type of Cancer/Illness: \_\_\_\_\_ Date of Treatment: \_\_\_\_\_

2. Name and Address of Diagnosing Physician:

\_\_\_\_\_

3. Name and Location of Hospital where Treated:

\_\_\_\_\_

**\*\* WE ONLY NEED ONE DOCUMENT THAT STATES THE DIAGNOSIS. THIS CAN BE LISTED ON THE DEATH CERTIFICATE \*\***

(mark if you would like our office to order medical records for you)

\*\* You will be responsible for the document fee plus an additional \$50 on any documents that we order for you. We will send back all provided and ordered documents at the end of the claim.

## **Presence Information about Your Parent:**

1. My parent participated in nuclear testing at the following test site:

- Nevada Test Site (Nevada)
- Trinity Test Site (New Mexico)
- Pacific Test Sites
- South Atlantic Test Site
- Any designated location in a government installation where equipment used in an atmospheric detonation was decontaminated
- Any designated location used for the purpose of monitoring fallout of an atmospheric nuclear test conducted at the Nevada Test Site.

Dates of Testing: \_\_\_\_\_

Names of Tests: \_\_\_\_\_

2. My parent participated in nuclear testing as a:

- Civilian
- Military Personnel
- Department of Defense contractor or personnel
- Atomic Energy Commission Employee
- Employee with any company contracted with AEC/DOE

**For Non- Military Participants:**

Name of Employer/Contractor: \_\_\_\_\_

Job Position: \_\_\_\_\_

Job Description and Duties: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For Military Personnel:**

Branch: (Army/Navy/Air Force/Marines) \_\_\_\_\_

Rank: \_\_\_\_\_

Unit: \_\_\_\_\_

Service Number: \_\_\_\_\_

**If you are Native American, please complete the following:**

Tribal Affiliation: \_\_\_\_\_ Chapter: \_\_\_\_\_

Census Number: \_\_\_\_\_

**If your parent was a Native American, please complete the following:**

Tribal Affiliation: \_\_\_\_\_ Chapter: \_\_\_\_\_

Census Number: \_\_\_\_\_

# RELEASE OF TRIBAL VITAL RECORDS

**\*\*ONLY FILL OUT IF YOU ARE NATIVE AMERICAN\*\***

**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 (2006).

X \_\_\_\_\_  
Signature, thumbprint or mark

\_\_\_\_\_  
Date

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The undersigned does hereby authorize and consent to disclose to Laura J. Taylor, Esq., 325 West Gurley, Suite 201, Prescott, Arizona 86301, *doctors office notes and records, radiology records and X-ray reports, reports of medical and diagnostic tests and examinations, medical, hospital and clinical records, documents and writings of every kind and description* relating to:

Name of Patient: \_\_\_\_\_ D.O.B. \_\_\_\_\_

The undersigned understands that the information in Patient's health records may include information relating to communicable disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

The undersigned understands that any disclosure of information carries with it the potential for further disclosure by the above-name recipient, and the information may not be protected by federal confidentiality rules.

The undersigned understands that authorizing the disclosure of this health information is voluntary; the undersigned can refuse to sign this authorization; the undersigned need not sign this authorization to insure treatment of any kind, and the undersigned may inspect or request a copy of the information to be used or disclosed as provided in CFR 164.524.

The undersigned may revoke this authorization at any time by providing written notice to Laura J. Taylor, Esq., 325 West Gurley, Suite 201, Prescott, Arizona 86301. Revocation will not apply to information that has already been released in response to this Authorization.

In addition to the above disclosure authorization and consent, the undersigned does authorize and request the furnishing of such of the above-mentioned records, documents and writings as may be requested by Laura J. Taylor, Esq., and by this instrument does hereby waive all provisions of law and all privileges relating to the said records, documents and writings and the information embraced thereby or reflected therein, provided however that this waiver is limited to and is in favor of Laura J. Taylor, Esq. and shall not be deemed to apply to any other persons.

Any recipient of this waiver, or any copy thereof, is hereby authorized to act and reply upon a reproduction copy of this release to the same extent as if it were an original.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. Expires one year from date of signature.

\_\_\_\_\_  
Signature of Client

Date of Service: \_\_\_\_\_

Provider: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Printed Name of Client: \_\_\_\_\_

Purpose of Request: For use by the Department of Justice (Radiation Exposure Compensation Program) and Laura J. Taylor for determining the eligibility of the client

**This authorization meets current HIPAA requirements for Authorizations.**

US. Department of Justice

## Certification of Identity and Privacy Act Release

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RADIATION EXPOSURE COMPENSATION PROGRAM  
CLAIM NO. 201-16-\_\_\_\_\_

**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 Status \_\_\_\_\_ Social Security Number \_\_\_\_\_

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 \_\_\_\_\_

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**Section 2: Authorization to Release Information to Another Person**

If you would like the Radiation 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: Law Offices of Laura J. Taylor Relationship to Requester: Attorney

Phone Number: 928-776-2457 Current Address: 325 West Gurley, Suite 201 Prescott, AZ 86301

Signature of individual authorizing this release \_\_\_\_\_ Date \_\_\_\_\_



### Authorization to Obtain Earnings Data from the Social Security Administration

Mail completed form to: Social Security Administration PO Box 33011 Baltimore, MD 21290-3011	Requesting organization: SSA Job No 8634 Index 01 DOJ Radiation Exposure Compensation Program Ben Franklin Station P.O. Box 146 Washington, D.C. 20044-0146
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#### Number Holder's Information

First Name:	<input style="width: 100%; height: 20px;" type="text"/>	Middle Initial:	<input style="width: 100%; height: 20px;" type="text"/>
Last Name:	<input style="width: 100%; height: 20px;" type="text"/>		
SSN:	<input style="width: 15%; height: 20px;" type="text"/> -- <input style="width: 15%; height: 20px;" type="text"/> -- <input style="width: 20%; height: 20px;" type="text"/>		
Date of Birth:	<input style="width: 15%; height: 20px;" type="text"/> -- <input style="width: 15%; height: 20px;" type="text"/> -- <input style="width: 20%; height: 20px;" type="text"/>	Date of Death:	<input style="width: 15%; height: 20px;" type="text"/> -- <input style="width: 15%; height: 20px;" type="text"/> -- <input style="width: 20%; height: 20px;" type="text"/>
	Month      Day      Year		Month      Day      Year
Other First, Middle Initial, and Last Name Used to Report Earnings:	<input style="width: 100%; height: 20px;" type="text"/>		
Year(s) Requested:	<input style="width: 15%; height: 20px;" type="text"/> through <input style="width: 15%; height: 20px;" type="text"/>	<input style="width: 15%; height: 20px;" type="text"/> through <input style="width: 15%; height: 20px;" type="text"/>	
	Y Y Y Y	Y Y Y Y	
	<input style="width: 15%; height: 20px;" type="text"/> through <input style="width: 15%; height: 20px;" type="text"/>	<input style="width: 15%; height: 20px;" type="text"/> through <input style="width: 15%; height: 20px;" type="text"/>	
	Y Y Y Y	Y Y Y Y	



I am the individual to whom the record/information applies or that person's parent (if a minor) or legal guardian, or a person who is authorized to sign on behalf of the individual to whom the record/information applies. Please furnish the requesting organization, or its designees, an itemized statement of all amounts of earnings reported to my record, or to the record identified above, for the periods specified on this form. Please include the identification numbers, names, and addresses of the reporting employers. **I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.**

Signature of Number Holder (or authorized representative)	Date <input style="width: 15%; height: 20px;" type="text"/> -- <input style="width: 15%; height: 20px;" type="text"/> -- <input style="width: 20%; height: 20px;" type="text"/>
	M M      D D      Y Y Y Y
Printed Name (if other than number holder)	Relationship (if other than number holder)
Address	<input type="checkbox"/> Spouse
State	<input type="checkbox"/> Legal Representative
	<input type="checkbox"/> Other (specify)
City	Phone Number
	ZIP Code

#### Requesting Organization's Information

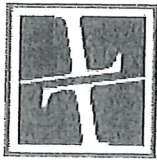
*SSA must receive this form within 120 days from the date signed by the Number Holder (or Authorized Representative)*

Signature of Organization Official	Date
Phone Number	Fax Number

FOR SSA USE ONLY     1     2     3     4







LAW OFFICES OF  
LAURA J. TAYLOR

**REPRESENTATION AGREEMENT AND GENERAL RELEASE**

This is an agreement between: The Law Offices of Laura J. Taylor, P.L.L.C., and

Name: \_\_\_\_\_ ("CLIENT")

The Law Offices of Laura J. Taylor, P.L.L.C. agrees to represent the CLIENT in the following:

**PREPARATION AND COMPLETION OF A RADIATION EXPOSURE  
COMPENSATION PROGRAM ("RECP") CLAIM**

The Law Offices of Laura J. Taylor, P.L.L.C. verifies the following:

- (1) Laura Taylor is currently in good standing with the Arizona State Bar, license no. 02-0031.
- (2) Laura Taylor is qualified to represent the CLIENT pursuant Radiation Exposure Compensation Program Act.

CLIENT represents the following:

- (1) I have hired the Law Offices of Laura J. Taylor, P.L.L.C. to represent me in the completion of a RECP claim.
- (2) This document may be used as confirmation that the Law Offices of Laura J. Taylor, P.L.L.C. is representing me with the completion of a RECP claim and may be used as a general release to collect documents on my behalf.
- (3) I am aware that pursuant to Section 9 of 42 U.S.C. § 2210, the Energy Employees Occupational Illness Compensation Program Act, the Law Offices of Laura J. Taylor will receive the following percentage of my RECP claim upon successful completion of the claim:
  - (a) 2 percent (of the total compensation available) for filing of the initial claim;
  - (b) 10 percent with respect to a resubmission of a denied claim.
- (4) I agree to return a \$100.00 file review fee to Ms. Taylor with this Agreement. I also agree to pay a \$200.00 processing fee at the conclusion of the claim to cover the cost of miscellaneous expenses incurred by the Law Offices of Laura J. Taylor, P.L.L.C. including the cost of telephone calls, copying expenses and miscellaneous expenses. I also agree to pay a \$50.00 research fee in addition to the actual cost of each document Ms. Taylor obtains on my behalf.

Client's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Attorney's signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Part 17: YOUR 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.

**X**

Signature of person identified in Part 1  
or Legal Guardian identified in Part 16

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).

**Privacy Act**

The authority for the collection of this information is the Radiation Exposure Compensation Act of 1990, 42 U.S.C. § 2210 note (2006). 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 11 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.