LAW OFFICES OF
LAURA J. TAYLOR

ON SITE PARTICIPANT CLIENT INFORMATION FORM - SPOUSE FILER

Your Information: (The person filing the claim)

1. First, Middle, Last Name: _____
2. Maiden Name (if applicable): _____ Any Prior Names: _____
3. Social Security Number: _____
4. Mailing Address: _____ City, State, Zip: _____
5. Residence Address: _____ City, State, Zip: _____
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 your spouse)

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 Spouse:

1. Your Spouse's name at birth: _____ Gender: ◯ M ◯ F

2. Date of Birth: _____ Place of Birth: _____

PLEASE PROVIDE THE BIRTH CERTIFICATE OF SPOUSE

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

3. Date of Death: _____ Place of Death: _____

PLEASE PROVIDE THE DEATH CERTIFICATE OF SPOUSE

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

4. Social Security Number: _____

5. Spouse's Mother's Full Maiden Name: _____

6. Spouse's Father's Name: _____

7. How many times has your spouse 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.

◯ _____

◯ _____

◯ _____

◯ _____

Your Spouse's Medical Information:

1. Type of Cancer: _____ 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 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 Spouse:

1. My spouse 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 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 spouse participated in nuclear testing as a:

   - ◯ Civilian
   - ◯ Miliary 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: _____

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

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 _____

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_____

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 <u>at the conclusion of the claim</u> 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:_____

Social Security Administration

Form Approved
OMB No. 0960-0602

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 1 DOJ RADIATION EXPOSURE COMPENSATION PROGRAM BEN FRANKLIN STATION PO BOX 146, WASHINGTON DC 20044-0146

Number Holder's Information

First Name: Middle Initial:

Last Name:

SSN: -- --

Date of Birth: -- -- (Month Day Year)

Date of Death: -- -- (Month Day Year)

Other First, Middle Initial, and Last Name Used to Report Earnings:

Year(s) Requested: Y Y Y Y through Y Y Y Y

Y Y Y Y through 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 -- -- (M M D D Y Y Y Y)
Printed Name *(if other than number holder)*	Relationship *(if other than number holder)* ☐ Spouse ☐ Legal Representative ☐ Other *(specify)*
Address / State	
City / ZIP Code	Phone Number

Requesting Organization's Information

SSA must receive this form within 60 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

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.