OMB Approval No. 1105-0052
Revised July 2025

Radiation Exposure Compensation Program Downwinder Claim Form

U.S. Department of Justice
Civil Division

GENERAL INSTRUCTIONS:

This form is an application for benefits under the Radiation Exposure Compensation Act (RECA), 42 U.S.C. § 2210 note, as amended by Pub. L. No. 119-21. Read the entire claim form and complete all necessary parts. There are four claimant categories under the Act: uranium workers (including miners, millers, ore transporters, core drillers, and/or remediation workers), downwinders, onsite participants, and individuals affected by Manhattan Project Waste. No individual may receive more than one payment under the Act. RECA § 7(b).

This form must be accompanied by certified or original supporting documentation. Failure to submit the required documentation will delay the processing of your claim. If you file electronically, you may upload photocopies of the required records and need not submit certified or original records unless they are requested by the RECA Program. You may access the electronic filing portal at www.justice.gov/civil/reca. If you have any questions, you may visit the RECA website or call 1-800-729-7327.

Part 1: YOU, the person filling out this form.

First Name

Middle Name

Last Name

Former Names or Maiden Name, if applicable

Social Security Number ___ - ___ - ____

Date of Birth (mm/dd/yyyy) __ / __ / ____

Mailing Address

City

State

Zip Code

Phone Number (day) ___ - ___ - ____

Phone Number (evening) ___ - ___ - ____

E-mail Address

Residence Address

If you are a member of an Indian Tribe and want the RECA Program to request tribal enrollment information, please provide your tribal affiliation and census number. You must also complete the Release of Tribal Vital Records attached to this form.

Tribe: _____

Census Number: _____

Have you received assistance from tribal organizations?

☐ YES – Navajo Uranium Workers' Program

☐ YES – Other: _____

☐ NO

Part 2: THE CLAIMANT, the person who became ill with a compensable disease. If YOU are the person who became ill, you may proceed to Part 3 and are NOT required to fill out Part 2.

First Name

Middle Name

Last Name

Former Names or Maiden Name, if applicable

Social Security Number - -

Date of Birth (mm/dd/yyyy) / /

Date of Death (mm/dd/yyyy) / /

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)

☐ **Spouse** (go to Part 5 on page 3)

☐ **Child** (go to Part 6 on page 4)

☐ **Parent** (go to Part 7 on page 6)

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

☐ **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: EXPOSURE. Please choose any of the following options that apply.

To be eligible for compensation, the claimant must have been physically present:

(1) in a designated affected area-

☐ for a period of at least one year during the period beginning on January 21, 1951, and ending on November 6, 1962; or

☐ for the entire period beginning on June 30, 1962, and ending on July 31, 1962; or

(2) in the State of New Mexico-

☐ for a period of at least one year during the period beginning on September 24, 1944, and ending on November 6, 1962.

Examine the list of geographical areas below. Find the area(s) in which the claimant was physically present. In the space next to the area(s), **print the name of the county and/or town where the claimant was present, and the time period when the claimant was present in each county and/or town or city.**

If the person was not physically present in any of the areas listed below for the required time period, you are not eligible for compensation.

Please choose from the following:

State	**Town or City**	**Time Period**
Idaho		
New Mexico		
Utah		

State	**County**	**Town or City**	**Time Period**
Arizona	Coconino		
Arizona	Yavapai		
Arizona	Navajo		
Arizona	Apache		
Arizona	Gila		
Arizona	Mohave		
Nevada	White Pine		
Nevada	Nye		
Nevada	Lander		
Nevada	Lincoln		
Nevada	Eureka		
Nevada	Clark (limited to townships 13 through 16 at ranges 63 through 71)		

Part 9: PROOF OF PRESENCE IN AN AFFECTED AREA.

This section describes methods to establish that the person who became ill was physically present in an affected area during the designated period.

Acceptable presence documentation will include the name of the person who became ill (or a member of his or her immediate family residing in the same household), indication of residence or full-time employment in an affected area, and a specific date. Documents that can be used to establish presence include, but are not limited to, the following:

- Tax Records
- School Records
- Employment Records
- Birth and Marriage Records
- Personal Letters or Envelopes
- Church/Religious Records
- Voting Records
- Personal Diaries

Unless you file electronically, you must provide certain *certified* or *original* documents to establish presence in an affected area. Photocopies of these documents, even if notarized, are not sufficient unless they are certified by the issuing institution.

Generally, there are two ways to certify documents showing presence:

Certified photocopies are often stamped with the seal of the issuing institution. Typically, these seals are either raised, colored or signed. If you have a document that has been stamped, send us that document.

OR

Ask the source of the record to attach a cover letter to the record (signed and dated on letterhead) stating, "the attached record(s) containing [# of pages] pertaining to [name of person in question] is a true and accurate copy of a record kept in our files." This cover page must be signed and attached to the relevant record(s).

Please Note: If you would like the Church of Jesus Christ of Latter-day Saints to help with your claim, **YOU** must call the Church at (801) 240-3500 or write to:

The Church of Jesus Christ of Latter-day Saints
Member and Statistical Records Division
Seventeenth Floor
50 East North Temple Street Salt Lake City, Utah 84150

and request that the Church send information confirming physical presence to the RECA Program.

☐ *I have contacted the Church of Jesus Christ of Latter-day Saints and requested information regarding my claim with the RECA Program.*

Part 10: COMPENSABLE DISEASES.

Examine the list of compensable diseases. Place a check next to the disease that the person who became ill developed. If you are not sure which disease the claimant contracted, you may check more than one box. The illnesses listed are the only diseases for which compensation is available under Section 4 of RECA.

☐ Leukemia (other than chronic lymphocytic leukemia)

☐ Multiple Myeloma

☐ Lymphomas (other than Hodgkin's disease)

☐ Primary cancer of the thyroid

☐ Primary cancer of the male or female breast

☐ Primary cancer of the esophagus

☐ Primary cancer of the stomach

☐ Primary cancer of the pharynx

☐ Primary cancer of the small intestine

☐ Primary cancer of the pancreas

☐ Primary cancer of the bile ducts

☐ Primary cancer of the gall bladder

☐ Primary cancer of the salivary gland

☐ Primary cancer of the urinary bladder

☐ Primary cancer of the brain

☐ Primary cancer of the colon

☐ Primary cancer of the ovary

☐ Primary cancer of the liver (except if cirrhosis or hepatitis B is indicated)

☐ Primary cancer of the lung

Part 11: PROOF OF DISEASE.

To establish that the person who became ill contracted a compensable disease, you will need to submit certain medical documentation reflecting a diagnosis of a covered cancer. 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." Documentation that may be used to establish a diagnosis of a compensable disease includes, but is not limited to, the following:

- pathology report of tissue biopsy or surgical resection
- operative report
- hospital discharge summary report
- physician summary report
- death certificate, dated and signed by a physician
- autopsy report

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

Some states have cancer registries which maintain records of individuals who have had cancer diagnosed in that state. *If you wish to have the RECA Program contact a state cancer registry to confirm a diagnosis of cancer, please mark the box 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.

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): North Country HealthCare- RESEP Flagstaff, AZ

Part 12: 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 13: 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 an annual statement of active membership and good standing of the bar of the highest court of a state, as provided in the regulations.

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 **Last Name**

Firm

Mailing Address

City **State** **Zip Code**

Phone Number **Fax Number**

E-mail Address

Part 14: ATTORNEY ACKNOWLEDGMENT.

I acknowledge that I have been retained by the claimant or beneficiary(ies) in this matter. I understand that only in the event of a successful outcome am I, along with any assistants or experts retained by me on behalf of the claimant or beneficiary(ies), entitled to receive the statutory fee in connection with a claim filed under the Radiation Exposure Compensation Act. I am permitted to recover costs and expenses regardless of whether the claim is approved or denied. I understand that I am entitled to receive the following:

☐ **2%** for the filing of an initial claim.

☐ **10%** 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.

X_____

Signature of Attorney representing claimant or beneficiary **Date**

Part 15: COURT APPOINTED LEGAL GUARDIANS.

PLEASE NOTE: A person who has power of attorney is NOT a legal guardian of that person. If you are a legal guardian, please submit certified or original court documentation showing power of guardianship over the person filing this claim.

First Name **Middle Name**

Last Name

Mailing Address

City **State** **Zip Code**

Phone Number (day) **Phone Number (evening)**

- -

E-mail Address

Part 16: 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 RECA entitlement.

X_____

Signature of person identified in Part 1 or Legal Guardian identified in Part 15 **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 10 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 for the state identified above to release any and all medical and other information in its possession, custody, and control to representatives of the Radiation Exposure Compensation Program (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 Status[1] _____ Social Security Number[2] _____

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 10 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.

MEDICAL RECORDS ATTACHMENT

Listed below are the specified compensable diseases and the records which the RECA Program shall accept as proof that the person who became ill had the specified compensable disease.

Tear off this attachment and take it to the doctor or hospital holding the records of the person who became ill with one of the specified compensable diseases listed below.

Show this list to the doctor or hospital and ask them to give you original or certified copies of one or more of the records listed below. Select the record(s) containing a diagnosis of the disease, if possible. Otherwise, send the records listed below that are available. If you have questions, call the Radiation Exposure Compensation Program at 1-800-729-7327.

(1) Leukemia, other than chronic lymphocytic leukemia.

(i) Bone marrow biopsy or aspirate report;
(ii) Peripheral white blood cell differential count report;
(iii) Autopsy report;
(iv) Hospital discharge summary;
(v) Physician summary;
(vi) History and physical report;
(vii) Death certificate, provided that it is signed by a physician at the time of death

(2) Multiple Myeloma.

(i) Pathology report of tissue biopsy;
(ii) Autopsy report;
(iii) Report of serum electrophoresis;
(iv) One of the following summary medical reports:
  (A) Physician summary report;
  (B) Hospital discharge summary report;
  (C) Hematology summary or consultation report;
  (D) Medical oncology summary or consultation report;
  (E) X-ray report;
(v) Death certificate, provided that it is signed by a physician at the time of death.

(3) Lymphomas, other than Hodgkin's disease.

(i) Pathology report of tissue biopsy;
(ii) Autopsy report;
(iv) One of the following summary medical reports:
  (A) Physician summary report;
  (B) Hospital discharge summary report;
  (C) Hematology consultation or summary report;
  (D) Medical oncology consultation or summary report;
(iv) Death certificate, provided that it is signed by a physician at the time of death.

(4) Primary cancer of the thyroid.

(i) Pathology report of tissue biopsy or fine needle aspirate;
(ii) Autopsy report;
(iii) One of the following summary medical reports:

(A) Physician summary report;
(B) Hospital discharge summary;
(C) Operative summary report;
(D) Medical oncology summary or consultation report;

(iv) Death certificate, provided that it is signed by a physician at the time of death.

(5) Primary cancer of the male or female breast.

(i) Pathology report of tissue biopsy or surgical resection;
(ii) Autopsy report;
(iii) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary;
(C) Operative report;
(D) Medical oncology summary or consultation report;
(E) Radiotherapy summary or consultation report;
(iv) Report of mammogram;
(v) Report of bone scan;
(vi) Death certificate, provided that it is signed by a physician at the time of death.

(6) Primary cancer of the esophagus.

(i) Pathology report of tissue biopsy or surgical resection;
(ii) Autopsy report;
(iii) Endoscopy report;
(iv) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Operative report;
(D) Radiotherapy report;
(E) Medical oncology consultation or summary report;
(v) One of the following radiological studies:
(A) Esophagram;
(B) Barium swallow;
(C) Upper gastrointestinal (GI) series;
(D) Computerized tomography (CT) scan;
(E) Magnetic resonance imaging (MRI);
(vi) Death certificate, provided that it is signed by a physician at the time of death.

(7) Primary cancer of the stomach.

(i) Pathology report of tissue biopsy or surgical resection;
(ii) Autopsy report;
(iii) Endoscopy or gastroscopy report;
(iv) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Operative report;
(D) Radiotherapy report;
(E) Medical oncology summary report;
(v) One of the following radiological studies:
(A) Barium swallow;

(B) Upper gastrointestinal (GI) series;
(C) Computerized tomography (CT) series;
(D) Magnetic resonance imaging (MRI);
(vi) Death certificate, provided that it is signed by a physician at the time of death.

(8) Primary cancer of the pharynx.
(i) Pathology report of tissue biopsy or surgical resection;
(ii) Autopsy report;
(iii) Endoscopy report;
(iv) One of the following summary medical reports:
(A) Physician summary;
(B) Hospital discharge summary;
(C) Report of otolaryngology examination;
(D) Radiotherapy summary report;
(E) Medical oncology summary report;
(F) Operative report;
(v) Report of one of the following radiological studies:
(A) Laryngograms;
(B) Tomograms of soft tissue and lateral radiographs;
(C) Computerized tomography (CT) scan;
(D) Magnetic resonance imaging (MRI);
(vi) Death certificate, provided that it is signed by a physician at the time of death.

(9) Primary cancer of the small intestine.
(i) Pathology report of tissue biopsy;
(ii) Autopsy report;
(iii) Endoscopy report, provided the examination covered the duodenum and parts of the jejunum;
(iv) Colonoscopy report, providing the examination covered the distal ileum;
(v) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary;
(C) Report of gastroenterology examination;
(D) Operative report;
(E) Radiotherapy summary report;
(F) Medical oncology summary or consultation report;
(vi) Report of one of the following radiologic studies:
(A) Upper gastrointestinal (GI) series with small bowel follow-through;
(B) Angiography;
(C) Computerized tomography (CT) scan;
(D) Magnetic resonance imaging (MRI);
(vii) Death certificate, provided that it is signed by a physician at the time of death.

(10) Primary cancer of the pancreas.
(i) Pathology report of tissue biopsy or fine needle aspirate;
(ii) Autopsy report;
(iii) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;

(C) Radiotherapy summary report;
(D) Medical oncology summary report;
(iv) Report of one of the following radiographic studies:
(A) Endoscopic retrograde cholangiopancreatography (ERCP);
(B) Upper gastrointestinal (GI) series;
(C) Arteriography of the pancreas;
(D) Ultrasonography;
(E) Computerized tomography (CT) scan;
(F) Magnetic resonance imaging (MRI);
(v) Death certificate, provided that it is signed by a physician at the time of death.

(11) Primary cancer of the bile ducts.
(i) Pathology of tissue biopsy or surgical resection;
(ii) Autopsy report;
(iii) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Operative report;
(D) Gastroenterology consultation report;
(E) Medical oncology summary or consultation report;
(iv) Report of one of the following radiographic studies:
(A) Ultrasonography;
(B) Endoscopic retrograde cholangiography;
(C) Percutaneous cholangiography;
(D) Computerized tomography (CT) scan;
(v) Death certificate, provided that it is signed by a physician at the time of death.

(12) Primary cancer of the gall bladder.
(i) Pathology report of tissue from surgical resection;
(ii) Autopsy report;
(iii) Report of one of the following radiological studies:
(A) Computerized tomography (CT) scan;
(B) Magnetic resonance imaging (MRI);
(C) Ultrasonography (ultrasound);
(iv) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Operative report;
(D) Radiotherapy report;
(E) Medical oncology summary or report;
(v) Death certificate, provided that it is signed by a physician at the time of death.

(13) Primary cancer of the salivary gland.
(i) Pathology report of tissue biopsy or resection;
(ii) Autopsy report;
(iii) Report of otolaryngology or oral maxillofacial examination;
(iv) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;

(C) Radiotherapy summary report;
(D) Medical oncology summary report;
(E) Operative report;
(v) Report of one of the following radiology examinations:
(A) Computerized tomography (CT) scan;
(B) Magnetic resonance imaging (MRI);
(vi) Death certificate, provided that it is signed by a physician at the time of death.

(14) Primary cancer of the urinary bladder.
(i) Pathology report of tissue biopsy or resection;
(ii) Autopsy report;
(iii) Report of cystoscopy, with or without biopsy;
(iv) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Radiotherapy summary report;
(D) Medical oncology summary report;
(E) Operative report;
(v) Report of one of the following radiology examinations:
(A) Computerized tomography (CT) scan;
(B) Magnetic resonance imaging (MRI);
(vi) Death certificate, provided that it is signed by a physician at the time of death.

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

(16) Primary cancer of the colon.
(i) Pathology report of tissue biopsy;
(ii) Autopsy report;
(iii) Endoscopy report, provided the examination covered the duodenum and parts of the jejunum;
(iv) Colonoscopy report, providing the examination covered the distal ileum;
(v) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary;
(C) Report of gastroenterology examination;
(D) Operative report;

(E) Radiotherapy summary report;
(F) Medical oncology summary or consultation report;
(vi) Report of one of the following radiologic studies:
(A) Upper gastrointestinal (GI) series with small bowel follow-through;
(B) Angiography;
(C) Computerized tomography (CT) scan;
(D) Magnetic resonance imaging (MRI);
(vii) Death certificate, provided that it is signed by a physician at the time of death.

(17) Primary cancer of the ovary.
(i) Pathology report of tissue biopsy or resection;
(ii) Autopsy report;
(iii) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Radiotherapy summary report;
(D) Medical oncology summary report;
(E) Operative report;
(iv) Death certificate, provided that it is signed by a physician at the time of death.

(13) Primary cancer of the liver (except if cirrhosis or hepatitis B is indicated).
(i) Pathology report of tissue biopsy or surgical resection;
(ii) Autopsy report;
(iii) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;
(C) Medical oncology summary report;
(D) Operative report;
(E) Gastroenterology report;
(iv) Report of one of the following radiological studies:
(A) Computerized tomography (CT) scan;
(B) Magnetic resonance imaging (MRI);
(v) Death certificate, provided that it is signed by a physician at the time of death.

(18) Primary cancer of the lung.
(i) Pathology report of tissue biopsy or resection, including, but not limited to specimens obtained by any of the following methods:
(A) Surgical resection;
(B) Endoscopic endobronchial or transbronchial biopsy;
(C) Bronchial brushings and washings;
(D) Pleural fluid cytology;
(E) Fine needle aspirate;
(F) Pleural biopsy;
(G) Sputum cytology;
(ii) Autopsy report;
(iii) Report of bronchoscopy, with or without biopsy;
(iv) One of the following summary medical reports:
(A) Physician summary report;
(B) Hospital discharge summary report;

(C) Radiotherapy summary report;
(D) Medical oncology summary report;
(E) Operative report;

(v) Report of one of the following radiology examinations:
(A) Computerized tomography (CT) scan;
(B) Magnetic resonance imaging (MRI);
(C) X-rays of the chest;
(D) Chest tomograms;

(vi) Death certificate, provided that it is signed by a physician at the time of death.