[Date]

[Claimant Name]
[Address]

Subject: Vaccine Injury Support Program Status of Claim

Option 1 – If the requester never submitted a claim to the VISP, or submitted a claim and has been found not eligible for VISP.

Dear [Name],

Please find enclosed the information you requested with respect to the Vaccine Injury Support Program (VISP).

We remain available to answer any questions that you may have at 1-833-489-0839.

Best regards,

VISP Team

Option 2 – If the requester submitted a claim to the VISP, including one that has not yet been assessed, is waiting on an appeal or has not yet been assessed.

Dear [Name],

Please find enclosed the information you requested on the status of your claim with the Vaccine Injury Support Program (VISP).

We wish to remind you that the VISP does not require claimants to waive their rights to pursue litigation. However, a settlement or damages awarded in litigation can affect the amount of financial support provided under the VISP.

As such, if you are receiving financial support from the VISP, you are required to inform us as soon as possible if you negotiate a settlement or are awarded damages in litigation against a

vaccine manufacturer, or have received or are currently receiving financial support for the same vaccine injury from any other sources.

We remain available to answer questions you may have at 1-833-489-0839.

Best regards,

VISP Team

Vaccine Injury Support Program Claim Status

As of **[date]**, the Vaccine Injury Support Program (VISP) confirms that **[Claimant's Name & address]** has:

☐ No active claim with the VISP

☐ Submitted a claim for the same vaccine injury related to a **[name of vaccine]** administered on **[date(s)]** and bearing **[Batch / Lot Number(s) if known######]** that is in the process of being assessed

☐ Been assessed as eligible for financial support under VISP in relation to the same vaccine injury related to a **[name of vaccine]** administered on **[date(s)]** and bearing **[Batch / Lot Number(s) if known######]**.

To date **[Claimant's Name]** has received the following financial support:

- income replacement payments totalling **[amount]**;
- injury indemnity payments totalling **[amount]**;
- death benefits totalling **[amount]**;
- coverage for funeral expenses totalling **[amount]**;
- reimbursement of eligible costs totalling **[amount]**

[Claimant's Name] is also currently eligible to receive the following ongoing financial support:

- income replacement payments;
- reimbursement of eligible costs

[Signature]

Vaccine Injury Support Program – Claim Intake

Date: March 8th, 2022
Version: 1.0
Prepared by: RCGT Consulting Inc.

1 Claim Intake

1.1 CONTEXT

The Claim Intake process for the Vaccine Injury Support Program (VISP) is described in this document. The Claim Intake process map in Section 5 describes the life cycle of the claim from Claim Intake to Board Review.

A Claimant can request the forms via:

- Online: https://vaccineinjurysupport.ca/
- Phone:1-833-489-0839
- Email: info@vaccineinjurysupport.ca
- Mail: 116 Albert St., Suite #1000, Ottawa, ON K1P 5G3

Upon VISP receiving these forms via mail, they are scanned and uploaded into the secure case management system. The first point of contact with the Claimant is initiated with a call from a VISP Client Service Representative confirming the receipt of the claim and that it will be assigned to a Case Manager within 2 weeks. Within the 2-week period, the Case Manager will call the Claimant for introductions, a further explanation of the program, next steps, and notify the Claimant of any missing information (i.e., signature on document, form incomplete).

The Case Manager then determines what information is needed for the Lead Physician to complete the Medical Record Checklist of a case and to determine which medical records are needed. The Case Manager will redact personally identifiable information from the documentation that must shared with the Lead Physician. Any non-medical essential documents such as attending physician invoices and Authorized Representative Forms are not shared with the Lead Physician.

Based on this Preliminary Assessment, the Case Manager proceeds to the Medical Record Retrieval process. Once the Medical Record Retrieval process is complete, the documents are depersonalized and shared with the Lead Physician for a Secondary Review.

The Lead Physician determines if the medical records obtained in the Medical Record Retrieval process are sufficient to move to Board Review. If it is determined that sufficient medical records have been obtained, the Lead Physician then identifies which medical specialists are needed to properly evaluate the case. The Case Manager then proceeds to select Board Members based on the Secondary Review recommendations. The depersonalized documents are then shared to Board Members, and the Board Review is scheduled.

2 Intake Form

Vaccine Injury Support Program

Forms Overview

Forms Overview

Canada Vaccine Injury Support Program

Step 1: To submit a claim to the Vaccine Injury Support Program, please complete all forms listed below. Failure to submit all forms may result in your case not being reviewed.

- ☑ Form 1 – Intake Form*
- ☑ Form 2 – Medical Assessment Form (to be completed by a licensed physician)
- ☑ Proof of Vaccination

* If submitting on behalf of someone else, Form 1 requires "APPENDIX A – Authorized Representative Form" to be completed.

Step 2: Once **Step 1** forms have been submitted, are complete and meet eligibility criteria, additional information will be required as eligible claims will be individually assessed by medical experts.

- The process will include a review of all required and relevant historical medical documentation, as well as current medical evidence, to determine if there is a probable link between the injury(ies) and the vaccine.
- If there is a probable link, the medical experts will also assess the severity and probable duration of the injury(ies). This information will be used to determine the type(s) and level(s) of financial support awarded to the individual or their survivor(s).

The personal information requested in these forms are being collected by the Vaccine Injury Support Program (VISP) administrator in accordance with and protected by the provisions of the Privacy Notice available at vaccineinjurysupport.ca. The VISP administrator is collecting, processing, storing, and sharing personal information to process claims. The collection of the personal information is necessary to support the claim submitted.

Please complete and submit the forms listed above ONLY if you meet the following eligibility criteria:

- Serious and permanent injury;
- Vaccinated in Canada**;
- Received a Health Canada authorized vaccine; and
- Vaccination date is on or after December 8, 2020.

** For vaccination administered in Quebec, please refer to Quebec Vaccine Injury Compensation Program (https://www.quebec.ca/en/health/advice-and-prevention/vaccination/vaccine-injury-compensation-program).

Please return the completed, signed and dated forms to the Vaccine Injury Support Program administrator by mail:

Mail: Vaccine Injury Support Program
116 Albert St. Suite 1000
Ottawa, Ontario
K1P 5G3

For more information, please contact us by phone: 1-833-489-0839, email: info@vaccineinjurysupport.ca or visit our website: www.vaccineinjurysupport.ca

The Vaccine Injury Support Program is funded by the Public Health Agency of Canada and administered by RCGT Consulting Inc.

Vaccine Injury Support Program

Form 1 – Intake Form

PROTECTED (when completed)

Intake Form (Form 1)
Canada Vaccine Injury Support Program

(to be completed by the injured party or the injured party's authorized representative)

Please complete all fields of the following form for vaccinations administered in Canada on or after December 8, 2020. If you are representing an injured party, someone who is deceased, a minor or someone that cannot represent themselves, please complete Appendix A – Authorized Representative Form.

For vaccinations administered in Québec, please refer to Québec's Vaccine Injury Compensation Program. (https://www.quebec.ca/en/health/advice-and-prevention/vaccination/vaccine-injury-compensation-program).

1 IDENTIFICATION AND CONTACT INFORMATION OF THE INDIVIDUAL SUBMITTING THE CLAIM

Note: please select all options that apply.

Identity of the individual submitting the claim	☐ Injured Party	The individual who received a Health Canada authorized vaccine, administered in Canada, on or after December 8, 2020.
	☐ Beneficiary	The beneficiary is the individual who is determined to be eligible and would ultimately receive financial support. The beneficiary can be the injured party, or in the cases where the injured party is deceased; the beneficiary may be a family member of the injured party (ex. spouse, children, dependent, etc.).
	☐ Authorized Representative	The authorized representative is an individual authorized to complete the claim on behalf of either the beneficiary or injured party. (if applicable, please complete Appendix A).

Note: please complete the following information if you selected ONLY beneficiary.

Surname (last name) _____ **Given name(s)** _____

Relationship to injured party _____ (Spouse, Father, Mother, Child, Legal Guardian, etc.)

Preferred language ☐ English ☐ French

Mailing address

Number/Street (include apt # if applicable) _____ City _____ Prov/Terr. _____ Country _____ Postal Code _____

Email address _____ **Primary telephone** _____ **Secondary telephone (if applicable)** _____

2 IDENTIFICATION AND CONTACT INFORMATION OF THE INJURED PARTY

Note: all information is required to be completed, unless otherwise specified.

Surname (last name) _____ **Given name(s)** _____

Residential address

Number/Street (include apt # if applicable) _____ City _____ Prov/Terr. _____ Country _____ Postal Code _____

Mailing address (if different from current residential address) ☐ Check if the same as above

Number/Street (include apt # if applicable) _____ City _____ Prov/Terr. _____ Country _____ Postal Code _____

Email address _____ **Primary telephone** _____ **Secondary telephone (if applicable)** _____

The Vaccine Injury Support Program is funded by the Public Health Agency of Canada and administered by RCGT Consulting Inc.

Place of birth

City | Prov./Terr. (if applicable) | Country

Date of birth	Sex	Preferred language
(YYYY-MM-DD)		☐ English ☐ French

3 RELEVANT DETAILS PERTAINING TO THE VACCINE INJURY

VACCINE ADMINISTRATION

Note: all information is required to be completed, unless otherwise specified.

Date of vaccination	Location where vaccination occurred	Province or Territory where vaccination occurred
(YYYY-MM-DD)	(private doctor office, hospital etc.)	Province or Territory

Vaccine name and/or Immunity against which disease (e.g., COVID-19, Measles, HPV, etc.)	Name of the individual who administered the vaccine (if known)

Manufacturer name (if known)	Date symptoms first appeared
(e.g., Pfizer, GlaxoSmithKline, Sanofi Pasteur etc.)	(YYYY-MM-DD)

FIRST MEDICAL CONSULTATION

Note: all information is required to be completed, unless otherwise specified.

Date of first medical consultation	Location of first medical consultation
(YYYY-MM-DD)	(private doctor office, hospital etc.)
Name of medical professional 1	**Primary telephone**

ADDITIONAL MEDICAL CONSULTATION(S)

Note: all information is required to be completed, unless otherwise specified.

Name of medical professional 2 (if applicable)	Location	Primary telephone
	(private doctor office, hospital etc.)	
Name of medical professional 3 (if applicable)	**Location**	**Primary telephone**
	(private doctor office, hospital etc.)	

Identification of the hospital(s) or clinic(s) providing care after the vaccination:

Description of the symptoms of adverse effects and/or injuries following vaccination

Vaccine Injury Support Program

Form 1 – Intake Form

PROTECTED (when completed)

4 IDENTIFICATION OF THE INJURED PARTY'S USUAL ATTENDING PHYSICIAN OR FAMILY PHYSICIAN

Note: if the Injured Party does not have a usual attending physician or family physician skip this section.

Name of physician: _____

Hospital / clinic name: _____

Location

Number/Street (include apt # if applicable)	City	Prov/Terr.	Country	Postal Code

Contact Information

Primary telephone _____

Secondary telephone (if applicable) _____

5 COMMENTS

Note: if no additional comments, skip this section.

Other Comments:

Warning: Any false or misleading statement contained with respect to the submitted claim or any supporting document, including the concealment of any material fact, may result in the refusal to process the claim.

By signing this form, I declare that all the information provided above is true and completed to the best of my knowledge. I also consent to the Vaccine Injury Support Program administrator collecting and using personal information present within these forms. This includes medical, employment, financial information and other documentation required to support and process this claim.

Signature of the Injured Party or the Injured Party's Authorized Representative _____

Date _____ YYYY-MM-DD

Please return the completed, signed and dated forms to the Vaccine Injury Support Program administrator by mail:

Mail: Vaccine Injury Support Program
116 Albert St., Suite 1000
Ottawa, Ontario
K1P 5G3

For more information, please contact us by phone: 1-833-489-0839, email: info@vaccineinjurysupport.ca or visit our website: www.vaccineinjurysupport.ca

The Vaccine Injury Support Program is funded by the Public Health Agency of Canada and administered by RCGT Consulting Inc.

3 Authorized Representative Form

Vaccine Injury Support Program

Appendix A – Authorized Representative Form

PROTECTED B (when completed)

APPENDIX A: Authorized Representative Form
Canada Vaccine Injury Support Program

(to be completed by injured party's authorized representative if applicable)

This form is only required if you are representing an injured party, someone who is deceased, a minor or someone that cannot represent themselves. Please complete all fields of the following form.

- Documentation to support the nature of the relationship may be required.

1 INJURED PARTY INFORMATION

Note: all information is required to be completed, unless otherwise specified.

Surname (last name)	Given name(s)

Date of Birth _____ (YYYY-MM-DD)

Status of Injured Party ☐ Minor ☐ Deceased ☐ Other (Please Specify) _____

2 AUTHORIZED REPRESENTATIVE INFORMATION

Note: all information is required to be completed, unless otherwise specified.

Surname (last name)	Given name(s)

Relationship to injured party	Preferred language
(Spouse, Father, Mother, Child, Legal Guardian, etc.)	☐ English ☐ French

Address

Number/Street (include apt # if applicable)	City	Prov/Terr.	Country	Postal Code

Email address	Primary telephone	Secondary telephone (if applicable)

3 IDENTIFICATION OF BENEFICIARY (IF DIFFERENT FROM INJURED PARTY OR AUTHORIZED REPRESENTATIVE)

Note: The beneficiary is the individual who is determined to be eligible and would ultimately receive financial support. All information is required to be completed, unless otherwise specified.

Surname (last name)	Given name(s)

Relationship to injured party	Preferred language
(Spouse, Father, Mother, Child, Legal Guardian, etc.)	☐ English ☐ French

Warning: Any false or misleading statement contained with respect to the submitted claim or any supporting document, including the concealment of any material fact, may result in the refusal to process the claim.

By signing this form, I understand that the authorized representative will act on behalf of the injured party or beneficiary. I also consent to the Vaccine Injury Support Program administrator collecting and using personal information present within these forms. This includes medical, employment, financial information and other documentation required to support and process this claim.

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Vaccine Injury Support Program

Appendix A – Authorized Representative Form

PROTECTED B (when completed)

If this authorization is cancelled or a new representative is selected, I must notify the Vaccine Injury Support Program administrator.

Signature of Injured Party (if applicable)	**Date**
_____	_____ YYYY-MM-DD
Signature of Authorized Representative	**Date**
_____	_____ YYYY-MM-DD
Signature of Beneficiary (if different from the Injured Party or the Authorized Representative)	**Date**
_____	_____ YYYY-MM-DD

Please return the completed, signed and dated forms to the Vaccine Injury Support Program administrator by mail:

Mail: Vaccine Injury Support Program
116 Albert St., Suite 1000
Ottawa, Ontario
K1P 5G3

For more information, please contact us by phone: 1-833-489-0839, email: info@vaccineinjurysupport.ca or visit our website: www.vaccineinjurysupport.ca

4 Medical Assessment Form

Vaccine Injury Support Program

Form 2 – Medical Assessment Form

PROTECTED (when completed)

Medical Assessment Form (Form 2)

Canada Vaccine Injury Support Program

This form must be completed by a licensed physician assessing the injured Party. Please complete all fields of the following form.

1 PHYSICIAN INFORMATION

Note: All information is required to be completed, unless otherwise specified.

Physician's surname (last name)	Physician's given name(s)

Primary address (of clinic/hospital/practice)

Number/Street (include apt # if applicable)	City	Prov/Terr.	Country	Postal Code

Mailing address (if different from above) ☐ Check if the same as above

Number/Street (include unit # if applicable)	City	Prov./Terr.	Country	Postal Code

Email address	Primary telephone	Secondary telephone (if applicable)

Medical license number or licensed practice number	Preferred language
	☐ English ☐ French

2 PATIENT (INJURED PARTY) INFORMATION

Note: All information is required to be completed, unless otherwise specified.

Patient's surname (last name)	Patient's given name(s)

Date of birth

YYYY-MM-DD

3 RELEVANT DETAILS PERTAINING TO THE VACCINE INJURY

Note: All information is required to be completed, unless otherwise specified.

Date and time of vaccination	Location where vaccination occurred	Province or Territory where vaccination occurred
(YYYY-MM-DD) – (HH:MM AM/PM)	(private doctor office, hospital etc.)	Province or Territory

Vaccine name and/or immunity against which disease (e.g., COVID-19, Measles, HPV, etc.)	Name of the individual who administered the vaccine (if known)

Batch/lot number (if known)	Expiry date (if known)	Dose number (1st, 2nd, etc.) (if known)
	(YYYY-MM-DD)	

Manufacturer name(s) (if known)	Date symptoms first appeared
(e.g., Pfizer, GlaxoSmithKline, Sanofi Pasteur etc.)	(YYYY-MM-DD)

The Vaccine Injury Support Program is funded by the Public Health Agency of Canada and administered by RCGT Consulting Inc.

Vaccine Injury Support Program

Form 2 – Medical Assessment Form

PROTECTED (when completed)

Patient status:	**If deceased, was an autopsy done? (complete if yes, or write future date if an autopsy is planned)**
☐ Deceased ☐ Recovered ☐ Unknown ☐ Recovering ☐ Other _____	_____ (YYYY-MM-DD)

Description of adverse effects and/or injuries following vaccination (initial and persistent) and Medical Diagnosis:

Available Documentation: *Instructions – List all documents (including imaging reports, Emergency Department and/or specialist consultations, injury assessment, discharge summary, clinical notes, laboratory reports and autopsy reports) that may be relevant to the Injured Party's case. The medical documentation listed here may be requested during the VISP assessment process.*

FIRST MEDICAL CONSULTATION
Note: all information is required to be completed, unless otherwise specified.

Date of first medical consultation	**Location of first medical consultation**
_____ (YYYY-MM-DD)	_____ (private doctor office, hospital etc.)
Name of medical professional 1	**Primary telephone**
_____	_____

ADDITIONAL MEDICAL CONSULTATION(S)
Note: all information is required to be completed, unless otherwise specified.

Name of medical professional 2	**Location**	**Primary telephone**
_____	_____ (private doctor office, hospital etc.)	_____
Name of medical professional 3	**Location**	**Primary telephone**
_____	_____ (private doctor office, hospital etc.)	_____

Identification of the hospital(s) or clinic(s) providing care after the vaccination:

_____

_____

_____

Adverse Events Following Immunization (AEFI) Report

If an AEFI report been submitted regarding this injury, please include a copy with this Medical Assessment Form.

The Vaccine Injury Support Program is funded by the Public Health Agency of Canada and administered by RCGT Consulting Inc.

Vaccine Injury Support Program

Form 2 – Medical Assessment Form

PROTECTED (when completed)

4 PATIENT MEDICAL HISTORY

Note: all information is required to be completed, unless otherwise specified.

Have you ever examined or treated this patient before the onset of the injury and/or disease potentially related to the vaccination?	☐ **Yes** ☐ **No**
Is there any relevant medical history or a cumulative patient profile (CPP)? Check no, if not applicable.	☐ **Yes** ☐ **No**

Please complete the following table:

Criteria	Finding	Remarks (If yes, provide details)
History of similar events	☐ Yes ☐ No ☐ Unknown	
Adverse events following immunization (AEFI) (vaccination)	☐ Yes ☐ No ☐ Unknown	
History of allergy to vaccine, drug, or food	☐ Yes ☐ No ☐ Unknown	
Pre-existing illness (30 days)/congenital	☐ Yes ☐ No ☐ Unknown	
History of hospitalization in the last 30 days, with cause	☐ Yes ☐ No ☐ Unknown	
Patient currently on concomitant medication? (If yes, name drug, indication, doses, and treatment dates)	☐ Yes ☐ No ☐ Unknown	
Family history of any disease (relevant to AEFI) or allergy?	☐ Yes ☐ No ☐ Unknown	

For women:

Currently pregnant? ☐ Yes (Specify number of months) _____ ☐ No ☐ Unknown

Currently Breastfeeding? ☐ Yes ☐ No

For infants:

The birth was: ☐ Full-term ☐ Pre-term ☐ Post-term Birth Weight: _____(lbs), _____(oz)

Delivery: ☐ Normal ☐ Cesarean ☐ Assisted (forceps, vacuum, etc.) ☐ Complications (Specify): _____

Additional Comments

NOTE - Specifics on adverse effects and/or injuries following vaccination will be completed above and do not need to be added here.

Vaccine Injury Support Program

Form 2 – Medical Assessment Form

PROTECTED (when completed)

5 COMMENTS

Note: if no additional comments, skip this section.

Other Comments:

Warning: Any false or misleading statement contained with respect to the submitted claim and any supporting document, including the concealment of any material fact, may result in the refusal to process the claim.

By signing this form, I declare that all information provided above is true and completed to the best of my knowledge.

Signature of the physician

Physician Signature

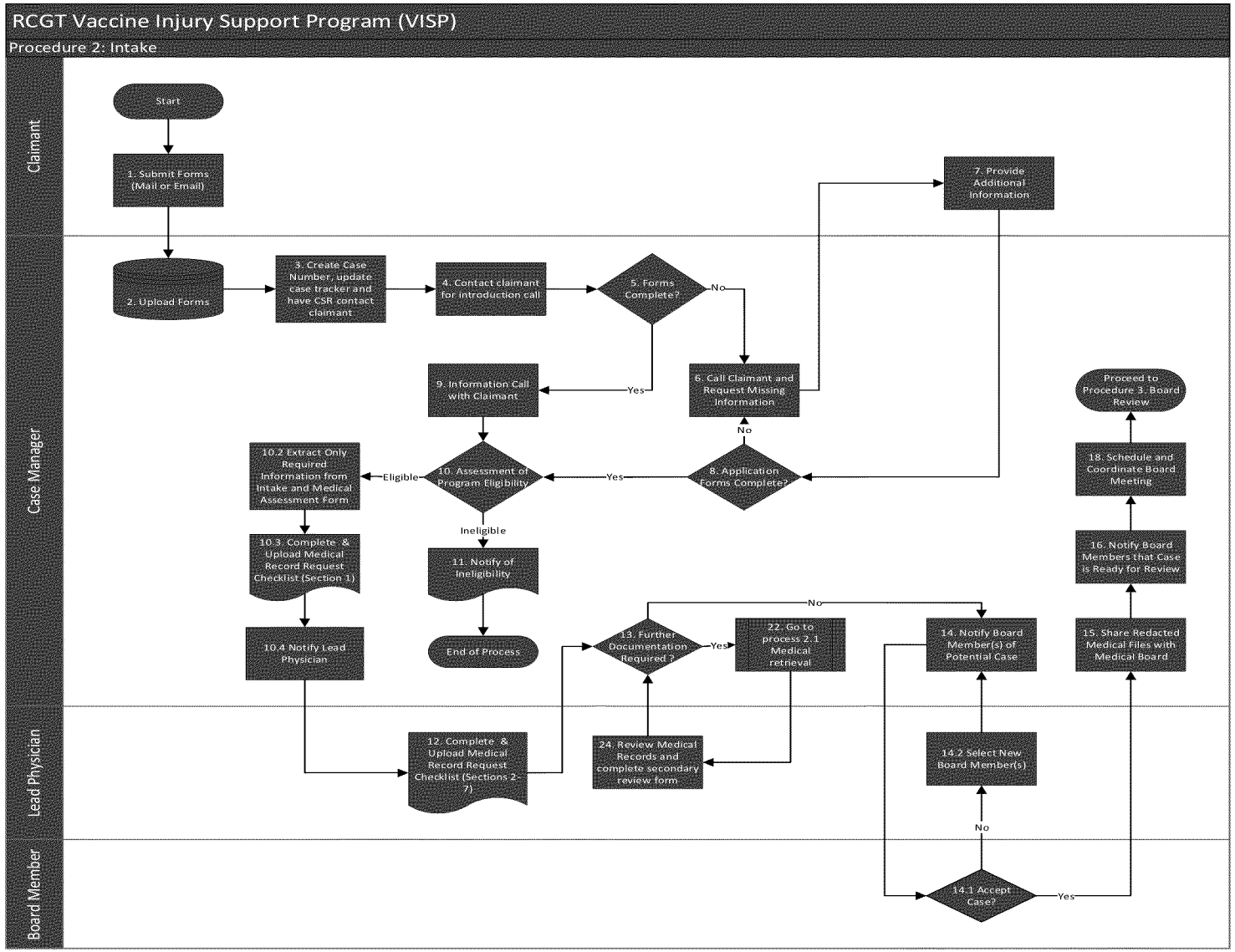
Date (YYYY-MM-DD)

Please return the completed, signed and dated forms to the Vaccine Injury Support Program administrator by mail:

Mail: Vaccine Injury Support Program
116 Albert St. Suite 1000
Ottawa, Ontario
K1P 5G3

For more information, please contact us by phone: 1-833-489-0839, email: info@vaccineinjurysupport.ca or visit our website: www.vaccineinjurysupport.ca.

5 Claim Intake Process Map



Vaccine Injury Support Program

vaccineinjurysupport.ca
soutienvictimesvaccination.ca

Vaccine Injury Support Program – Appeals

Date: March 22nd, 2022
Version: 1.2
Prepared by: RCGT Consulting Inc.

1 Appeals

The following document includes the appeals form and the corresponding appeals process for the Vaccine Injury Support Program (VISP).

1.1 CONTEXT

All claimants are provided with information on the appeals process (i.e. verbally from the Case Manager as well as in writing). If an appeal is requested, Case Managers can assist the claimant in determining which section of an appeal is being sought and what supporting documentation may be required. Claimants will have the ability to apply again to the VISP if new information is available (i.e: new medical literature, or change in injury), this would not be considered an appeal.

The appeals process has three possibilities:

1. Pre-Medical Board Review Appeal
    a. This will be used for addressing the decision of ineligibility.
2. Post Medical Board Review Appeal of Causality
    a. This will be used for addressing any appeal pertaining to causality.
3. Post Medical Board Review Appeal of Severity
    a. This will be used for addressing any appeal pertaining to severity.

If the Injured Party decides to pursue an appeal, a Request for Appeal form (Sect. 2 Appeals Form) must be received by the VISP within 67 days of the notification of decision. The additional 7 days have been added to accommodate for possible mailing delays. During this time, the Case Manager is available to the Injured Party to answer any questions they may have. If no Request for Appeal form is submitted, the case will be considered closed.

The Medical Review Board will be comprised of different medical experts than those involved as part of the initial assessment. However, the records collected as part of the initial Board Review, in addition to the Board Review's decisions and comments will also be used in the appeal Board Review, as per standard medical second opinion practices. The Injured Party and Board Members will be given an opportunity to request that new medical records be considered as part of the appeal. The Medical Record Retrieval process can be initiated in the event that new Medical Records or an evolution of the injury has occurred since the last collection of records.

If a Injured Party is appealing the severity decision, the new Board Review may determine the severity is lower or higher then the initial Board Review's severity assessment. If this is the case, the higher severity determination of the two Board Reviews will be granted as the final decision.

The decision rendered on an appeal will be considered final and the decision cannot be appealed again. However, individuals can submit a new claim for assessment only if new reliable evidence from a recognized source has arisen to support a causal relationship between the injury and/or the progression of an injury.

Further details regarding the appeals process can be found in Section 3 (Appeals Process) and Section 4 (Board Review Process).

2 Appeals Form

Vaccine Injury Support Program

Appeal Form
PROTECTED (when completed)

Request for Appeal

Vaccine Injury Support Program

(To be completed by injured party or injured party's authorized representative)

Please complete all fields of the following form **only if you wish to appeal** the decision that the Vaccine Injury Support Program (VISP) made on your claim. Your appeal must be submitted by _____ in order to be processed.

Injured Party's Full Name: _____

Case Number: _____

Please note following a request for an appeal there will be a full reassessment of the case. In the case of an appeal pertaining to causality or severity, new Board Members will be selected. **Please select the reason for your appeal:**

- ☐ I have been deemed ineligible but believe I meet the program eligibility requirements.
- ☐ I disagree with the decision that the association between my injury and the vaccination is not related.
- ☐ I disagree with the severity assessment or believe my injuries are more serious and permanent then what the Medical Board determined.

Please describe any additional detail or documentation for your appeal:

By signing below, I acknowledge that the information provided above is complete and comprehensive to the best of my knowledge. ***I understand that if I appeal my case, the decision following the reassessment cannot be appealed again.***

Signature of Injured Party or Authorized Representative _____

Date _____
YYYY-MM-DD

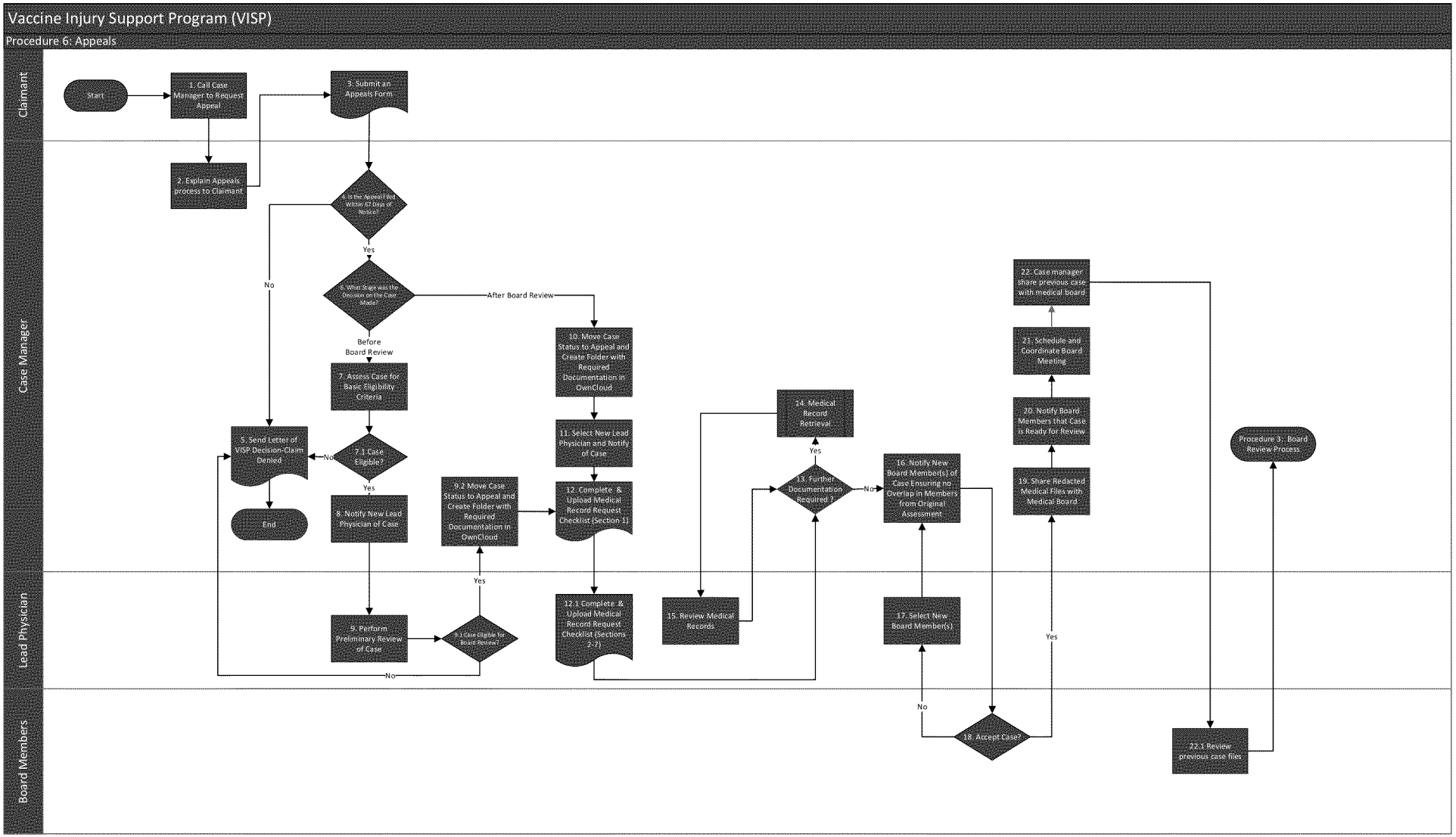
Please return the completed, signed and dated forms to the Vaccine Injury Support Program administrator by mail:

Mail: Vaccine Injury Support Program
116 Albert St., Suite 1000
Ottawa, Ontario
K1P 5G3

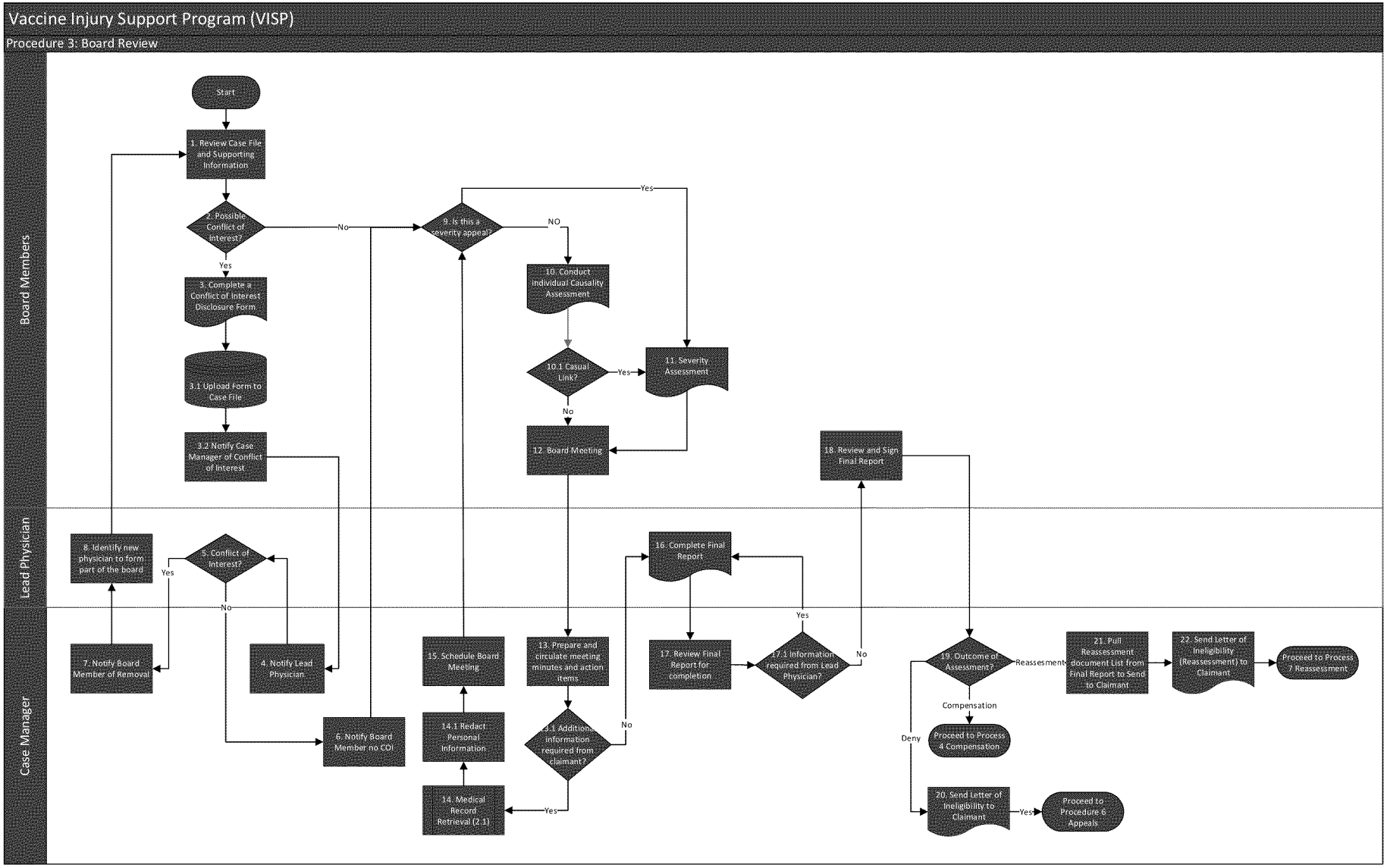
For more information, please contact us by Phone: 1-833-489-0839, Email: info@vaccineinjurysupport.ca or visit our website: www.vaccineinjurysupport.ca

The Vaccine Injury Support Program is funded by the Public Health Agency of Canada and administered by RCGT Consulting Inc. Page 1 of 1

3 Appeals Process



4 Board Review Process



Vaccine Injury Support Program

vaccineinjurysupport.ca
soutienvictimesvaccination.ca