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[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

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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.

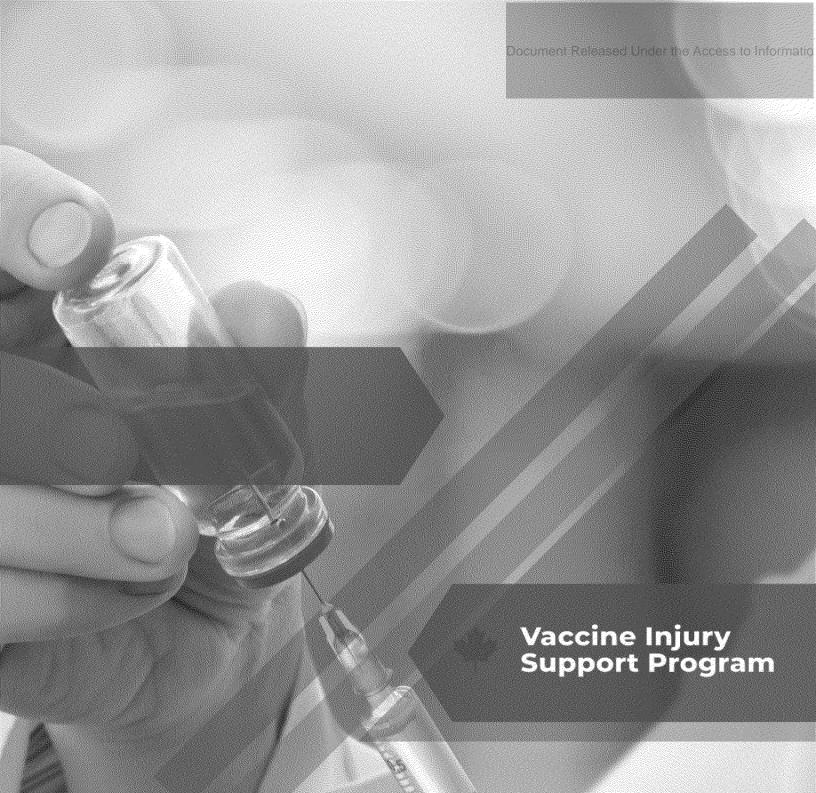
Best regards,

VISP Team



Vaccine Injury Support Program Claim Status

	ss] 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
[Signa	ture]



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).

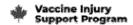
The Case Manager then determines what information is needed for the Lead Physician to complete the Medical Record Checklist of a case and to determine which medical records are needed. The Case Manager will redact personally identifiable information from the documentation that must shared with the Lead 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



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.

(Controlled)				
M	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 QNLY 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).

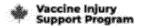
Please return the completed, signed and dated forms to the Vaccine Injury Support Program administrator by mail:

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 or www.vaccineinjurysupport.ca o

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





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).

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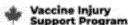
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Page 1 of 3



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Form 1 – Intake Form

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3 Authorized Representative Form



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 co	mpleted, unless othe	rwise specified.		
Surname (last name)		Given name(s)		
Date of Birth (1977-MM-DD)			5-7/19 (VE 50/19 (VE	
Status of Injured Party Minor	Deceased [Other (Please Specify)		
2 AUTHORIZED REPRESENTATIVE I	NFORMATION			
Note: all information is required to be co	mpleted, unless othe	rwise specified.		
Surname (last name)		Given name(s)		
Relationship to injured party				Preferred language
(Spouse, Father, Mother, Child, Legal Guardian, etc.)	F.			French
Address				
Number/Street (include apt # if applicable)	City	Prov/Terr,	Country	Postul Code
Email address	Primary telep	hone	Secon	dary telephone (if applicab
3 IDENTIFICATION OF BENEFICIAR	Y (IF DIFFERENT FROM	I INJURED PARTY OR AUT	HORIZED R	EPRESENTATIVE)
Note: The beneficiary is the individual wi All information is required to be complet			rately receiv	re financial support.
Surname (last name)		Given name(s)		
Relationship to injured party	and extended and the state of t			Preferred language
(Spouse, Father, Mother, Child, Legal Guardian, etc.)				French

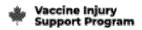
Warning: Any false or misleading statement contained with respect to the submitted claim or any supporting document, including the concealment of any material fact, may result in the refusal to process the claim.

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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Page 1 of 2





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-00
Signature of Authorized Representative	Date
	YYYY-MM-00
Signature of Beneficiary (if different from the Injured Party or the Authorized Representative)	Date
	YYYY-MM-00
Please return the completed, signed and dated forms to the Vaccine Injury Support Program admini	strator by mail:

Mail: Vaccine Injury Support Program

116 Albert St., Suite 1000

Ottawa, Ontario K1P 5G3

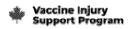
For more information, please contact us by phone: 1-833-489-0839, email: info@vaccineinjurysupport.ca or visit our website: www.vaccineiniurysupport.ca

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4 Medical Assessment Form



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	l, unless c	otherwise specifi	ed.		
Physician's surname (last name)			Physician's giv	en name(s)		
Primary address (of clinic/hospital)	oractice)	***************************************		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	,					
Number/Street (include apt # if applicable)	City		Prov/Terr.	Country		Postal Code
Mailing address (if different from a	- party	rk if the s	ame as above	SOUTH COLUMN		7 2705 2706
Extracordor Contra de Cont		5000. TO 101.100 D	TOOR IVELSTONE SHE WE WANTED THE TO SHE			
Number/Street (include unit # if applicable)	City		Prov./Terr.	Country		Postal Code
Email address	en de la companie de La companie de la companie de	Drimary (telephone	COURTER	Secondary tele	phone (if applicable)
Bud a design for the state of t		a sussemble	recording two sec		nermines à rese	humas in obburanci
		·····		***************************************		
Medical license number or licensed	l practice num	ber				Preferred language
						☐ English
						French
2 PATIENT (INJURED PARTY)	***************************************					
Note: All information is required to	be completed	l, uniess o	1	*************	********************************	
Patient's surname (last name)			Patient's given	name(s)		
Date of birth						
YYYY-MM-00	*********************			^^=		
3 RELEVANT DETAILS PERTA	INING TO THE	VACCINE	INJURY			
Note: All information is required to	be completed	l, unless (otherwise specifi	ed.		
Date and time of vaccination	ocation where	e vaccinal	tion occurred	Province o	r Territory where va	accination occurred
				100000000000000000000000000000000000000	×	
(YYYY-MM-00) - (HH:MM AM/PM) (Vaccine name and/or Immunity ag	private doctor offi			Province or T		vaccine (if known)
(e.g., COVID-19, Measies, HPV, etc.)	ainst which dis	ease	name of the in	idiryidililali yyt	io administered the	saccine (ii known)
Significant and the control of the c						
Ph. 2 B 71 c B 757 5 5	I F 1 - 4	/2/ 1				488 1 DEL1
Batch/lot number (if known)	Expiry a	ate (if kn	ownj		Dase number (1",	2 nd , etc.) (if known)
	(YYYY-MM	E CHITA'S				
Manufacturer name(s) (if known)	F Auto-Same	-ray)		Date syn	i optoms first appears	ed
R # # 4						
(e.g., Pfizer, GlaxoSmithKline, Sanofi Pasteur	etc.)			(YYYY-MM-	00)	

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Vaccine Injury Support Program

Form 2 – Medical Assessment Form

T Support Program			PROTECTED (when completed)
Patient status:	If deceased, was an auto	psy done? (complet	e if yes, or write future date if an autopsy is
☐ Deceased ☐ Recovered	planned)		
Unknown Recovering			
Other	(YYYY-MM-DD)		
Description of adverse effects and/or in	iuries following vaccinatio	in finitial and persist	tent) and Medical Diagnosis:
Available Documentation: Instructions -	List all documents fincludi	ing imaging reports,	Emergency Department and/or specialist
			and autopsy reports) that may be relevant to
the Injured Party's case. The medical doc	umentation listed here mo	y be requested durin	ig the VISP assessment process.
FIRST MEDICAL CONSULTATION			
Note: all information is required to be o	ompleted, unless otherwi	se specified.	
Date of first medical consultation		Location of first m	edical consultation
(YYYY-MM-DD)		(private doctor office, b	
Name of medical professional 1		Primary telephone	ł
ADDITIONAL MEDICAL CONSULTATION(nanggangangangan ballika di
Note: all information is required to be o		se specified.	
Name of medical professional 2	Location		Primary telephone
23.2.4.2.1.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2		The Books I	35524544111114440000000000000000000000000
Name of medical professional 3	(private doctor office, hosp		Primary telephone
name of measural professional a	- LAKAMAN		Linial Landina
	(private doctor office, hosp		
Identification of the hospital(s) or clinic	s) providing care after the	e vaccination:	
		000000000000000000000000000000000000000	
Adverse Events Following Immunization	(AEFI) Report	900000000000000000000000000000000000000	
If an AEFI report been submitted regard	ing this injury, please incli	ude a copy with this	Medical Assessment Form.

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Page 2 of 4





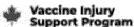
Form 2 - Medical Assessment Form

Support Program		PROTEC	TED (whe	n completed)
4 PATIENT MEDICAL HISTORY	2 2 2			T12 14-14
Note: all information is required to be comple			ymentumos sumano	nikirusiki (unuompormanniki kirombol
Have you ever examined or treated this patier potentially related to the vaccination?	n before the onset of the injury a	mayor onsease	☐Yes	☐ No
is there any relevant medical history or a cum-	ulative patient profile (CPP)? Che	ck no, if not applicable.	Yes	☐ No
Please complete the following table:			1	
Criteria	Finding	Remarks (If yes, provide	details)	Alexandra (September 1980)
History of similar events	☐Yes ☐ No ☐ Unknown			25299 AUGUSTER BANKES (1000 BANKOOK
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	900 \$1 H-2 Mon P Communic A-2 P A 2 P A 10 Mon A		
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) \[\bigcap \	lo 🔲 Unknown		
Currently Breastfeeding? Yes No				
For infants:				
The birth was: Full-term Pre-term Po	st-term Birth Weight:	(lbs),(cz)	Ė	
Delivery: Normal Cesarean Assisted	forceps, vacuum, etc.) 🔲 Compli	cations (Specify):		
Additional Comments				
NOTE - Specifics on adverse effects and/or injuries follow	ng vaccination will be completed above a	ind do not need to be added he	T Con	

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Page 3 of 4





www.vaccineiniurysupport.ca.

Form 2 - Medical Assessment Form

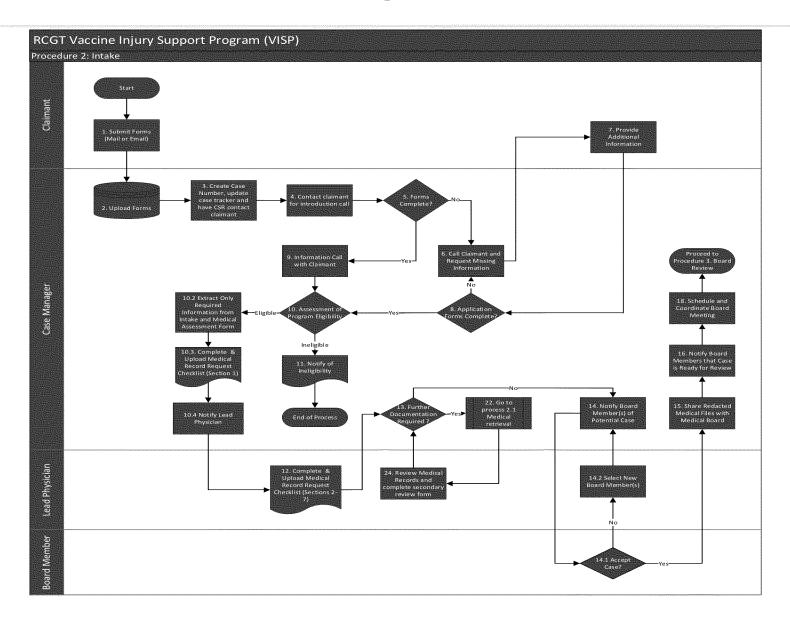
		PROTECTED (when completed)
\$	COMMENTS	
Note: i	f no additional comments, skip this section.	
	Comments:	
Appropriate to the control of	Application of the state of the	
	g this form, I declare that all information provided above of the physician	ove is true and completed to the best of my knowledge.
walk's experience	e at the bulkarions	
Physicia	n Signature	Date (YYYY-MM-DD)
7 		
Please re	eturn the completed, signed and dated forms to	the Vaccine Injury Support Program administrator by mail:
Mail:	Vaccine Injury Support Program	
PW BEETS L	116 Albert St. Suite 1000	
	Ottawa, Ontario	
	K1P 5G3	
	V11, 5/13	
Ent mos	s information alogue contact or he chosen 1.93	3-489-0839, email: info@vaccineinjurysupport ca or visit our website:
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5 Claim Intake Process Map



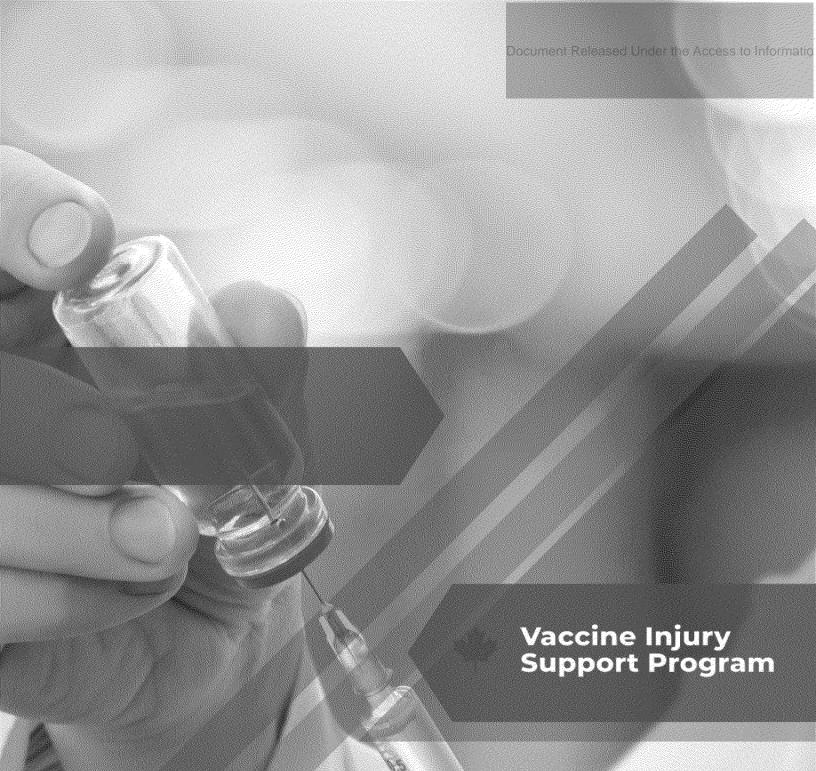
Page **13** of **14**

Document Released Under the Access to Informatic

Vaccine Injury Support Program

vaccineinjurysupport.ca soutienvictimesvaccination.ca

Page: 17 of/de 23A2022000319



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

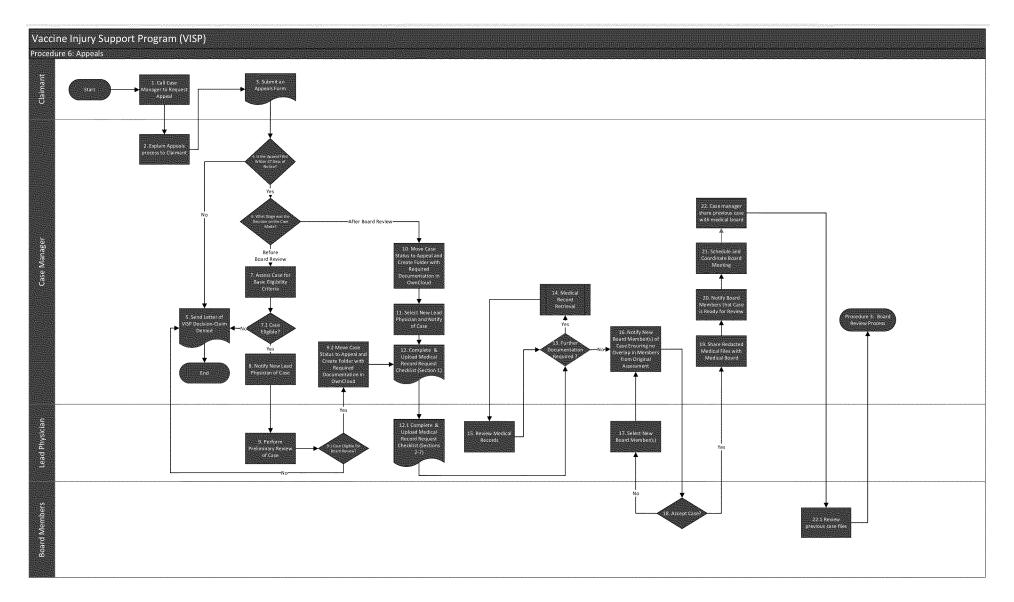
	Request for A	Appeal
	Vaccine Injury Supp	oort Program
	(To be completed by injured party or injured	
Please c	complete all fields of the following form only if you wish to appe	
	on your claim. Your appeal must be submitted by	
Injure	ed Party's Full Name:	
Case I	Number:	
	note following a request for an appeal there will be a full reas ty or severity, new Board Members will be selected. Please selec	
編	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.
[] Please d	I disagree with the severity assessment or believe my injuries Board determined. describe any additional detail or documentation for your appeal.	·
EE	Board determined.	·
By signín	Board determined.	e and comprehensive to the best of my knowledge. I understand th
By signin	Board determined. describe any additional detail or documentation for your appeal. describe any additional detail or documentation for your appeal.	e and comprehensive to the best of my knowledge. I understand th
By signin	Board determined. describe any additional detail or documentation for your appeal ing below, I acknowledge that the information provided above is completed in your case, the decision following the reassessment cannot be appeal	e and comprehensive to the best of my knowledge. I understand the ed again.
By signin f I appea Signat	Board determined. describe any additional detail or documentation for your appeal ing below, I acknowledge that the information provided above is completed in your case, the decision following the reassessment cannot be appeal	e and comprehensive to the best of my knowledge. I understand th ed again. Date YYYY-MM-DD

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Page 1 of 1

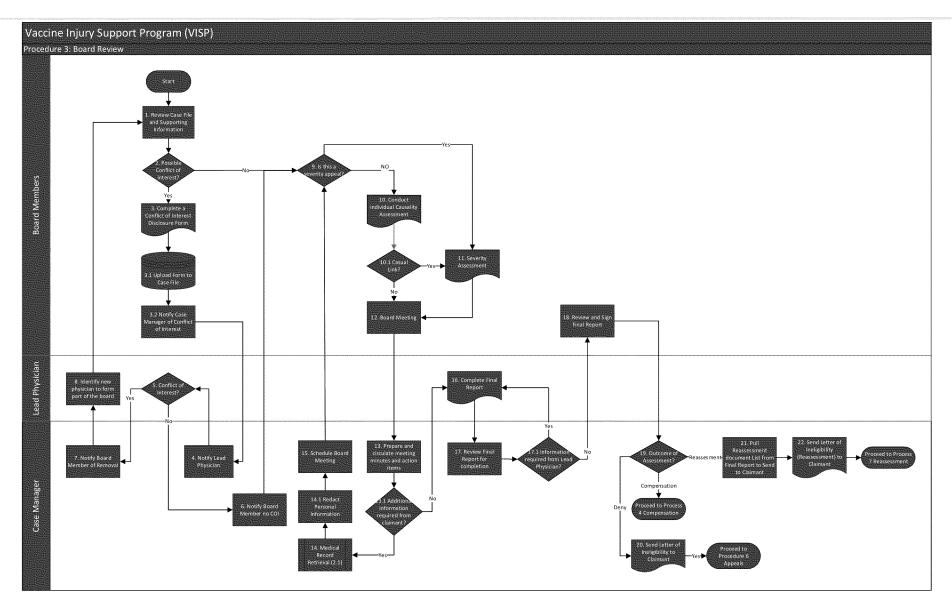


3 Appeals Process





4 Board Review Process



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