



Protected when completed.

Veterans Affairs Canada
Office Use Only
Client Identifier

Physician's Statement for ex gratia payment

A - Information About Applicant/Deceased

To be completed by applicant or primary caregiver.

PLEASE NOTE: If you are applying for yourself and as a primary caregiver you and your family doctor will need to complete two (2) "Physician Statements", one for yourself and one for the deceased you are applying on behalf of.

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss Other (please specify) _____		
Family name	Given name(s)	Date of birth (yyyy-mm-dd)

B - Physician Information

To be completed by your family doctor or other treating physician of applicant/deceased.

The Government of Canada is offering an ex gratia payment in response to uncertainties around the testing of Unregistered US Military herbicides, including Agent Orange, at CFB Gagetown in 1966 and 1967.

An application is being made for this ex gratia payment by the above-named individual.

The applicant/deceased must have been diagnosed with one or more of the medical conditions that are listed on page 2 of this form. The diagnosis must have been made between June 1, 1966, and June 30, 2011. Please indicate the condition(s) your patient was diagnosed with and include the earliest date of medical diagnosis for those medical conditions.

Once you have completed Section C and D, please return the form to the individual applying so that this information can be included with their application.

PLEASE NOTE:
Any fee associated with the completion of this form will be the responsibility of the applicant.

C - Physician Details

Physician's name (please print)	Tel. No. (include area code)
Physician's mailing address (include postal code)	

D - Medical Information

To be completed by family doctor or other treating physician of applicant/deceased.

Was your patient or was the deceased diagnosed with one or more of the medical conditions listed below: Yes No

PLEASE NOTE: The diagnosis must have been made between June 1, 1966, and June 30, 2011.

If YES, please indicate the condition(s) and the dates of medical diagnosis for each condition in the line provided next to each condition.

- Non-Hodgkin's lymphoma _____
- Hodgkin's disease _____
- Chloracne _____
- Chronic Lymphocytic Leukemia (CLL) _____
- Soft-tissue sarcoma _____
- Respiratory cancers, including cancers of the lung, larynx, trachea and bronchus _____
- Prostate cancer _____
- Multiple myeloma _____
- Acute and subacute (or early onset) transient peripheral neuropathy _____
- Porphyria cutanea tarda _____
- Type 2 diabetes (mellitus) _____
- Spina bifida _____

The personal information on this form is collected under the authority of the *Privacy Act* for the purpose of authorizing the release of the indicated information to the individual noted above. Provision of the information is on a voluntary basis.

The personal information collected on this form is protected from unauthorized disclosure by the *Privacy Act*. The *Privacy Act* also provides individuals with a right of access to personal information about themselves under the control of the Department, as well as a right to challenge the accuracy and completeness of their personal information and have it amended as appropriate.

For further information on the above statement, contact the Access to Information and Privacy Coordinator's Office, Veterans Affairs Canada, PO Box 7700, Charlottetown, PE, C1A 8M9. Please quote Personal Information Bank number VAC PPU 200.

Physician's signature

Date (yyyy-mm-dd)