KPMG Inc. Use Only Claimant No. _____

Application to Pre-1986/Post 1990 Hepatitis C Settlement Fund
Physician Form for Secondarily Infected Claimants
FORM C

About this Form: The Canadian Red Cross Society and others have established the Pre-1986/Post-1990 Hepatitis C Settlement Fund (the "HCV Fund") to provide compensation to persons infected with Hepatitis C prior to 1986 and after 1990. The following information is required to assist the Claimant and/or a person with a related claim (such as a Secondarily Infected Claimant, who may have contracted HCV from the Claimant, or a Family Claimant) in obtaining assistance under the program. The Claimant has provided KPMG Inc. and anyone acting on its behalf for the purpose of administering this HCV Fund with the authority to collect this information from you.

Claimant's Authorization to Disclose Information
I hereby authorize the physician named on this form to disclose to KPMG Inc. or anyone acting on its behalf for the purpose of administering the Pre-1986/Post-1990 Hepatitis C Settlement Fund (the "HCV Fund") any information in his or her possession regarding myself and to provide KPMG Inc. or anyone acting on its behalf for the purpose of administering the HCV Fund, with copies of any records in his or her possession regarding myself, and for so doing this is good and sufficient authority.

_____ _____
(Claimant's signature) (Date)

1. Claimant's Information (to be completed by Claimant)

Last name	First name	Middle initial	Date of birth (day/month/year)
Social Insurance Number		Provincial/Territorial Health Insurance Number	
Address	City	Province/Territory	Postal Code
Telephone no. (home)		Telephone no. (business) - optional	

2. Physician's Information (to be completed by physician)

Physician's name	Registration/License No.	Specialty
Business address		Telephone no.

3. General Medical Information (to be completed by physician)

How long have you been Claimant's physician?	Is Claimant diagnosed with Hepatitis C (HCV)? ☐ Yes ☐ No **If yes, attach a copy of the earliest laboratory test confirming this diagnosis (REQUIRED).**
Did you make the diagnosis? ☐ Yes ☐ No	When was Claimant diagnosed? (day/month/year)

To the best of your knowledge, did the Claimant contract HCV from a Primarily Infected Claimant (a person who received HCV contaminated blood, blood derivatives or blood products in any Canadian province or territory)?
☐ Yes ☐ No ☐ Unknown

Please provide the name of the Primarily Infected Claimant from whom this Claimant contracted HCV if known:

Name ☐ Unknown

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4. General Medical Information continued (to be completed by physician)

How did the Claimant contract HCV from the Primarily Infected Claimant?

☐ sexual contact
☐ perinatal transmission
☐ other (specify) _____

Comments:

To the best of your knowledge, has the Claimant ever used intravenous drug other than under the direction of a licensed medical practitioner?

☐ Yes ☐ No

Other comments

Physician signature	**Date**