KPMG Inc. Use Only
Claimant No. _____

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

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 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 with HCV? (day/month/year)

Did Claimant receive a transfusion in Canada during any or all of the following time period(s)
☐ on or before December 31, 1985 ☐ January 1, 1986 - July 1, 1990 ☐ July 2, 1990 - September 28, 1998 ☐ All

Reason for transfusion

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

Name of hospital(s) where transfusion occurred (if known) and provide copies of any hospital and/or physicians' records documenting the transfusion(s) in your possession:

Name of hospital (1)	Date of transfusion	City	Province/Territory
Name of hospital (2)	Date of transfusion	City	Province/Territory
Name of hospital (3)	Date of transfusion	City	Province/Territory

Is Claimant a hemophiliac? ☐ Yes ☐ No

If **yes**, did Claimant receive blood products in Canada during any or all of the following time period(s)?
☐ on or before December 31, 1985 ☐ January 1, 1986 - July 1, 1990 ☐ July 2, 1990 - September 28, 1998 ☐ All

If **yes**, did Claimant receive Factor VIII concentrate manufactured by Connaught Laboratories Limited between January 1, 1982 and December 31, 1984 inclusive?
☐ Yes ☐ No

If yes, please provide copies of medical or other records showing the receipt of those products. (REQUIRED)

To the best of your knowledge, has the Claimant ever used intravenous drugs other than under the direction of a licensed medical practitioner ?
☐ Yes ☐ No

Other comments

Physician signature	**Date**