





**Part 3: RELATIONSHIP TO THE PERSON WHO BECAME ILL.**

**Please indicate your relationship to the person who became ill and follow the appropriate directions.**

- Self** (go to Part 4 on page 3)
- Child** (go to Part 6 on page 4)
- Spouse** (go to Part 5 on page 3)
- Authorized Agent, such as an executor of estate, legal guardian or conservator** (go to Part 7 on page 6)

**Part 4: SELF-FILERS, individuals who became ill and are filing for themselves.**

**Required documents:** Unless you have filed electronically, you will need to provide *certified or original* copies of the documents requested in this claim form to support this claim (photocopies, even if notarized, are not sufficient unless certified by the issuing institution).

- Birth certificate: yours.
- Marriage certificate(s): documenting *all* changes of name, if applicable.

If you are a SELF-FILER, please continue to Part 8 of the claim form. You should NOT fill out Parts 5, 6, and 7.

**Part 5: SURVIVING SPOUSE, the individual who was married to the person who became ill for at least one year prior to his or her death.**

Please answer the following questions:

Is the person identified in Part 2 deceased? If "NO," you are not eligible to file this claim.  
**YES**  **NO**

Were you married to the claimant, the person who became ill, for at least one year immediately prior to his or her death? If "NO," you are not eligible to file this claim.  
**YES**  **NO**

Was the person who became ill married to anyone else BEFORE he or she married you?  
**YES**  **NO**

If "YES," please list the name of each previous spouse and the dates which the marriage began and ended.

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Have you ever been married to anyone else other than the person who became ill?

YES  NO

If "YES," please list the name of each spouse and the dates which the marriage began and ended.

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**Required documents:** Unless you have filed electronically, A SURVIVING SPOUSE must provide *certified or original* copies of the documents requested in this claim form to process this claim (photocopies, even if notarized, are not sufficient unless certified by the issuing institution).

- Birth certificate: of the person who became ill.
- Death certificate: of the person who became ill.
- Marriage certificate: documenting your marriage to the person who became ill.
- Marriage certificate(s): documenting any previous marriages of the person who became ill, if applicable.
- Divorce decree(s) or death certificate(s): documenting the end of any previous marriages of the person who became ill, if applicable.
- Birth certificate: yours.
- Marriage certificate(s): documenting all of your other marriages, if applicable.
- Divorce decree(s) or death certificate(s): documenting the end of any of your marriages before your marriage to the claimant.

If you are a SURVIVING SPOUSE, please continue to Part 8 of the claim form. You should NOT fill out Parts 4, 6, or 7.

**Part 6: SURVIVING CHILD, an individual who was a natural, adopted, or step-child of the person who became ill.**

Please answer the following questions:

Is the person identified in Part 2 (the person who became ill) deceased? If "NO," you are not eligible to file this claim.

YES  NO

Was the person who became ill ever married?

YES  NO

If "YES," please list the name of each spouse and the dates which the marriage began and ended.

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Are you a natural child, adopted child, or step-child of the decedent?

NATURAL  ADOPTED CHILD  STEP-CHILD

Did the decedent have any other natural, adopted, or step-children? YES  NO

If so, list the name of each child, date and place of birth, phone number, and current address or date and place of death.

1) Name: \_\_\_\_\_ Date and place of birth: \_\_\_\_\_

Date and place of death, if applicable: \_\_\_\_\_

Current address, if applicable: \_\_\_\_\_

Phone number, if applicable: \_\_\_\_\_

2) Name: \_\_\_\_\_ Date and place of birth: \_\_\_\_\_

Date and place of death, if applicable: \_\_\_\_\_

Current address, if applicable: \_\_\_\_\_

Phone number, if applicable: \_\_\_\_\_

3) Name: \_\_\_\_\_ Date and place of birth: \_\_\_\_\_

Date and place of death, if applicable: \_\_\_\_\_

Current address, if applicable: \_\_\_\_\_

Phone number, if applicable: \_\_\_\_\_

If there are more children of the claimant, please use the back of this page or attach another sheet to provide the information requested above and check here:

**Required documents:** Unless you have filed electronically, A SURVIVING CHILD must provide *certified or original* copies of the documents requested in this claim form to process this claim (photocopies, even if notarized, are not sufficient unless certified by the issuing institution).

Birth certificate: of the person who became ill.

Death certificate: of the person who became ill.

Marriage certificate(s): of the person who became ill.

Divorce decree(s) or death certificate(s): documenting that all marriages of the person who became ill have ended.

Birth certificate or papers of adoption: yours.

Marriage certificate(s): documenting all of your name changes, if applicable.

If you are a step-child of the person who became ill, send proof that their spouse was one of

your natural parents and any records which show that you lived with the person who became ill in a regular parent-child relationship (for example, school records).

Death certificates: of any siblings that have passed away.

In addition, the RECA Program will need identification documents for **ALL** other eligible surviving children of the person who became ill including:

Birth certificate for each eligible surviving beneficiary

Marriage certificate(s) for each eligible surviving beneficiary, where a change of name has occurred.

**If you would like to expedite your claim, please have each eligible surviving beneficiary review the claim form and sign their name on the page titled Attached Signatures of Eligible Surviving Beneficiaries.**

If you are a SURVIVING CHILD, please continue to Part 8 of the claim form. You should NOT fill out Parts 4, 5, or 7.

**Part 7: AUTHORIZED AGENTS of the person who became ill.**

What is your relationship to the person who became ill?

EXECUTOR OF ESTATE     LEGAL GUARDIAN   
CONSERVATOR         OTHER

If you are an AUTHORIZED AGENT of the person that became ill, you must provide documentation such as a representation agreement, appointment, or court order establishing your authority to act on behalf of the person who became ill or their estate.

**Part 8: EXPOSURE.**

To be eligible for compensation, the claimant must have been physically present in a statutorily designated affected area for a period of at least two years (24 months cumulatively or consecutively) after January 1, 1949.

Examine the list of geographical areas on the page. Check the boxes of the zip codes(s) in which the claimant was physically present. In the space next to the area(s), print the town where the claimant was present, and the time period when the claimant was present in each area.

If the person was not physically present in any of the zip codes listed below for the required period, you are not eligible for compensation.

State	Zip Codes <input type="checkbox"/> (Check all that apply)	Town and Dates Present (Month/Year – Month/Year)
Missouri	<input type="checkbox"/> 63031 <input type="checkbox"/> 63033 <input type="checkbox"/> 63034 <input type="checkbox"/> 63042 <input type="checkbox"/> 63045 <input type="checkbox"/> 63074 <input type="checkbox"/> 63114 <input type="checkbox"/> 63135 <input type="checkbox"/> 63138 <input type="checkbox"/> 63044 <input type="checkbox"/> 63121 <input type="checkbox"/> 63140 <input type="checkbox"/> 63145 <input type="checkbox"/> 63147 <input type="checkbox"/> 63102 <input type="checkbox"/> 63304 <input type="checkbox"/> 63134 <input type="checkbox"/> 63043 <input type="checkbox"/> 63341 <input type="checkbox"/> 63368 <input type="checkbox"/> 63367	
Tennessee	<input type="checkbox"/> 37716 <input type="checkbox"/> 37840 <input type="checkbox"/> 37719 <input type="checkbox"/> 37748 <input type="checkbox"/> 37763 <input type="checkbox"/> 37828 <input type="checkbox"/> 37769 <input type="checkbox"/> 37710 <input type="checkbox"/> 37845 <input type="checkbox"/> 37887 <input type="checkbox"/> 37829 <input type="checkbox"/> 37854 <input type="checkbox"/> 37830 <input type="checkbox"/> 37831	
Alaska	<input type="checkbox"/> 99546 <input type="checkbox"/> 99547	

Kentucky	<input type="checkbox"/> 42001 <input type="checkbox"/> 42003 <input type="checkbox"/> 42086	
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**Part 9: PROOF OF PRESENCE IN AN AFFECTED AREA.**

This section describes methods to establish that the person who became ill was physically present in an affected area during the designated period.

In order to establish presence, you will need to submit certified or original documentation that demonstrates the presence of the person who became ill within an affected area for at least 2 years (24 months cumulatively or consecutively) after January 1, 1949.

For purposes of determining physical presence, a claimant must establish the following:

- € The claimant’s primary residence was in the affected area;
- € The claimant’s place of employment was in the affected area; or
- € The claimant attended school in the affected area.

Acceptable presence documentation will include either (A) contemporaneous written residential documentation or at least 1 additional employer-issued or government-issued document that the claimant, for at least 2 years after January 1, 1949, was physically present in an affected area; or (B) the name of the person who became ill (or a member of his or her immediate family residing in the same household); indication of residence, employment, or education in an affected zip code; and a specific date.

Documents that can be used to establish presence include, but are not limited to, the following:

- |                                  |                               |
|----------------------------------|-------------------------------|
| Tax Records (property tax rolls) | Personal Letters or Envelopes |
| School Records                   | Church/Religious Records      |
| Employment Records               | Voting Records                |
| Birth and Marriage Records       | Personal Diaries              |

Unless you file electronically, you must provide certain certified or original documents to establish presence in an affected area. Photocopies of these documents, even if notarized, are not sufficient unless they are certified by the issuing institution.

Generally, there are two ways to certify documents showing presence:

Certified photocopies are often stamped with the seal of the issuing institution. Typically, these seals are either raised, colored or signed in ink. If you have a document that has been stamped, send us that document.

**OR**

Ask the source of the record to attach a cover letter to the record (signed and dated on letterhead) stating, "the attached record(s) containing [#of pages] pertaining to [name of person in question] is a true and accurate copy of a record kept in our files." This cover page must be signed in ink and attached to the relevant record(s).

## **Part 10: COMPENSABLE DISEASES.**

Examine the list of compensable diseases. Place a check next to the disease that the person who became ill developed. To qualify, the onset of any disease must have occurred at least 2 years after initial exposure. If you are not sure which disease the claimant contracted, you may check more than one box. The illnesses listed are the only diseases for which compensation is available under Section 5A of RECA.

- |   |  |
|---|--|
| <input type="checkbox"/> Any Leukemia (provided initial exposure occurred after age 20) | <input type="checkbox"/> Primary cancer of the bile ducts  |
| <input type="checkbox"/> Multiple Myeloma   | <input type="checkbox"/> Primary cancer of the gall bladder  |
| <input type="checkbox"/> Lymphoma, other than Hodgkin's disease                         | <input type="checkbox"/> Primary cancer of the salivary gland  |
| <input type="checkbox"/> Primary cancer of the thyroid                                  | <input type="checkbox"/> Primary cancer of the urinary bladder   |
| <input type="checkbox"/> Primary cancer of the male or female breast                    | <input type="checkbox"/> Primary cancer of the brain   |
| <input type="checkbox"/> Primary cancer of the esophagus                                | <input type="checkbox"/> Primary cancer of the colon   |
| <input type="checkbox"/> Primary cancer of the stomach                                  | <input type="checkbox"/> Primary cancer of the ovary   |
| <input type="checkbox"/> Primary cancer of the pharynx                                  | <input type="checkbox"/> Primary cancer of the bone  |
| <input type="checkbox"/> Primary cancer of the small intestine                          | <input type="checkbox"/> Primary renal cancer  |
| <input type="checkbox"/> Primary cancer of the pancreas                                 | <input type="checkbox"/> Primary cancer of the liver (except if cirrhosis or hepatitis B is indicated) |
|   | <input type="checkbox"/> Primary cancer of the lung  |

**Part 11: PROOF OF DISEASE.** To establish that the person who became ill contracted a compensable disease, you will need to submit certain medical documentation reflecting a diagnosis of a covered cancer. For a complete list of the specific documents accepted for each illness, consult the Medical Records Attachment at the end of this form. To certify the record, ask your source of the record (hospital or doctor's office) to attach a cover letter to the record stating, "the attached medical records consisting of [# of] pages pertaining to [the person who became ill] are true and accurate copies of records kept in our files." Documentation that may be

used to establish a diagnosis of a compensable disease includes, but is not limited to, the following:

- pathology report of tissue biopsy or surgical resection
- operative report
- hospital discharge summary report
- physician summary report
- death certificate, dated and signed by a physician
- autopsy report

I HAVE SUBMITTED CERTIFIED MEDICAL RECORDS SHOWING A DIAGNOSIS OF A COMPENSABLE CANCER

Some states have cancer registries which maintain records of individuals who have had cancer diagnosed in that state. *If you wish to have the RECA Program contact a state cancer registry to confirm a diagnosis of cancer, please mark the box below and complete the authorization to release medical information attached to this claim form.*

I WANT THE RECA PROGRAM TO CONTACT A STATE CANCER REGISTRY AND I HAVE SIGNED THE AUTHORIZATION TO RELEASE MEDICAL INFORMATION.

Have you received assistance from a Radiation Exposure Screening and Education Program (RESEP) clinic?

YES  NO

Please specify which clinic assisted you (if you do not know the name of the clinic, please state the location of the clinic): \_\_\_\_\_

## **Part 12: PREVIOUS PAYMENTS OF MONEY.**

Have you or anyone else received any payment of money pursuant to final award or settlement on a claim (other than a claim for worker's compensation) against any person (including a corporation), that is based on the illness for which this claim is submitted? Please check "YES" if you have already received an award under RECA on behalf of the claimant identified in this application, even if the payment was based on a different illness than the one claimed here.

YES  NO

If you checked "YES," please attach a statement identifying the date, amount, and person or organization from whom EACH AND EVERY payment of money was received, and explain the circumstances surrounding the payment.

Have you or anyone else filed a claim under the Department of Labor's Energy Employees Occupational Illness Compensation Program Act (EEOICPA)?





**Part 15: SIGNATURE.**

*We cannot process this claim form if you do not sign this page.*

I declare under penalty of perjury that the information in this claim is true, correct, and complete to the best of my knowledge and belief. I acknowledge that any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided under RECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may be punished by a fine or imprisonment or both.

I authorize the Department of Justice to share information provided in my claim with the Department of Labor, Office of Workers Compensation Programs. I further authorize any physician or hospital (or any other person, institution, corporation, or government agency, including the Social Security Administration) to furnish any desired information to the U.S. Department of Justice, Civil Division, for purposes of determining entitlement under RECA.

X \_\_\_\_\_

**Signature of person identified in Part 1**

**Date**

**Civil Penalty for Presenting a Fraudulent Claim or Making False Statements or Using False Records**

The declarant shall forfeit and pay to the United States the sum of \$10,000 plus treble the amount of damages sustained by the United States. (See 31 U.S.C. Section 3729).

**Criminal Penalty for Presenting a Fraudulent Claim or Making False Statements** Fine and imprisonment for not more than 5 years. (See 18 U.S.C. Sections 287 and 1001).

You may file this form by mailing it to:

Radiation Exposure Compensation Program  
U.S. Department of Justice  
P.O. Box 146  
Ben Franklin Station  
Washington, DC 20044-0146

**Privacy Act**

The authority for the collection of this information is the Radiation Exposure Compensation Act, 42 U.S.C. § 2210 note, as amended by Pub. L. 119-21. The information you provide will be used to verify your identity, to verify your eligibility, and to verify any previous payments made in connection with the compensable disease you identified in Part 10 of the claim form. Some or all of the information you provide may be released to federal, state, and local government agencies or private organization for the purpose of confirming your identity, your eligibility, and any previous payments made in connection with the compensable disease. The information may also be released when otherwise authorized by statute or regulation. Disclosure of the information by you is voluntary; however, it may not be possible to process your claim without the information.

**Reporting Burden**

Public Reporting burden for this collection of information is estimated to average 2.5 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining that data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection of information, including suggestions for reducing this burden to: Radiation Exposure Compensation Program, U.S. Department of Justice, P.O. Box 146, Ben Franklin Station, Washington, DC 20044-0146.

**U.S. Department of Justice  
Civil Division**

**AUTHORIZATION TO RELEASE  
MEDICAL AND OTHER  
INFORMATION FROM A STATE  
CANCER REGISTRY**

STATE OF RESIDENCE AT TIME OF DIAGNOSIS: \_\_\_\_\_

I hereby authorize the cancer registry for the state identified above to release all medical and other information in its possession, custody, and control to representatives of the RECA Program, Department of Justice, relating to the individual whose name appears on line 1 of this form. This data is required to determine eligibility for benefits under the Radiation Exposure Compensation Act, 42 U.S.C. § 2210 note.

For the RECA Program to request medical information on your behalf, you must **SIGN THIS FORM.**

1. Name of the individual whose records are to be released (First, Middle, Maiden, Last, Other).

\_\_\_\_\_

2. Social Security number of the individual whose records are to be released.

\_\_\_\_\_

3. Birth date of the individual whose records are to be released.

\_\_\_\_\_

4. Date of death of individual whose records are to be released, if applicable.

\_\_\_\_\_

5. Name of the individual requesting release of information and relationship to the individual listed on line 1, if different.

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**X**

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Signature

Date

Return this authorization with the claim form to:

Radiation Exposure Compensation Program  
U. S. Department of Justice  
P.O. Box 146  
Ben Franklin Station  
Washington, D.C. 20044-0146

**Certification of Identity  
and  
Privacy Act Release**



**RADIATION EXPOSURE COMPENSATION PROGRAM**

**CLAIM NO.** \_\_\_\_\_

**Privacy Act Statement.** The purpose of this request is to ensure that records of individuals that are maintained by the Radiation Exposure Compensation Program of the U.S. Department of Justice are not wrongfully disseminated. In accordance with 28 CFR Section 16.41(d) personal data sufficient to identify the individuals submitting requests for information under the Privacy Act of 1974, 5 U.S.C. Section 552a, is required. False information on this form may subject the requester to criminal penalties under 18 U.S.C. Section 1001 and/or 5 U.S.C. Section 552a(i)(3).

**Section 1: Certification of Identity. Please certify your identity. (The individual filing this claim.)**

Full Name \_\_\_\_\_

Citizenship Status<sup>1</sup> \_\_\_\_\_ Social Security Number<sup>2</sup> \_\_\_\_\_

Current Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. Section 1001 by a fine of not more than \$10,000 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. 552a(i)(3) by a fine of not more than \$5,000.

Signature of individual filing this claim \_\_\_\_\_ Date \_\_\_\_\_

**Section 2: Authorization to Release Information to Another Person (OPTIONAL)**

If you would like the RECA Program staff to provide information to someone other than yourself about your claim, you must complete the section below.

Pursuant to 5 U.S.C. Section 552a(b), I authorize the U.S. Department of Justice to release any and all information relating to me and my claim to:

Print or Type Name \_\_\_\_\_ Relationship to Requester \_\_\_\_\_

Phone Number \_\_\_\_\_ Current Address \_\_\_\_\_

Signature of individual authorizing this release \_\_\_\_\_ Date \_\_\_\_\_

<sup>1</sup> Individuals submitting a request under the Privacy Act of 1974 must be either "a citizen of the United States or an alien lawfully admitted for permanent residence," pursuant to 5 U.S.C. Section 552a(a)(2). Requests will be processed as Freedom of Information Act requests pursuant to 5 U.S.C. Section 552, rather than Privacy Act requests, for individuals who are not United States citizens or aliens lawfully admitted for permanent residence.

<sup>2</sup> Providing your social security number is voluntary. You are asked to provide your social security number only to facilitate the identification of records relating to you. Without your social security number, the Department may be unable to locate any or all records pertaining to you.



## RELEASE OF TRIBAL VITAL RECORDS

**Please check the applicable box so that we may verify information through the tribe of which you are a member:**

TO: THE NAVAJO NATION OFFICE OF VITAL RECORDS   
THE HOPI TRIBE ENROLLMENT DEPARTMENT   
SAN CARLOS APACHE TRIBAL ENROLLMENT OFFICE   
\_\_\_\_\_  
Other Tribal Records Office

RE: AUTHORIZATION TO RELEASE INFORMATION

**Claimant Name (Please print):** \_\_\_\_\_

I hereby authorize the release of vital statistics information and/or records held by the \_\_\_\_\_ (name of tribal organization) to a representative of the Radiation Exposure Compensation Program of the United States Department of Justice pursuant to 5 U.S.C. § 552a(b). This information is required to determine eligibility for compensation under the Radiation Exposure Compensation Act, 42 U.S.C. § 2210 note.

**X** \_\_\_\_\_  
**Signature, thumbprint or mark**

\_\_\_\_\_  
**Date**

## ATTACHED SIGNATURES OF ELIGIBLE SURVIVING BENEFICIARIES

If you are filing as a surviving child, you may expedite your claim by having each of your siblings review the claim and sign their name below. It is NOT necessary to have all surviving beneficiaries fill out this page, but the RECA Program will have to individually contact all eligible surviving beneficiaries who do not sign this page. Fill out this page ONLY if you are a surviving child of the person who became ill with a compensable disease. If you are a legal guardian signing on behalf of a surviving child, please indicate your status below.

*By signing this page, you declare under penalty of perjury that the information in this claim is true, correct, and complete to the best of your knowledge and belief.*

1. Name of Eligible Surviving Beneficiary (Please print): \_\_\_\_\_  
Social Security number: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Eligible Surviving Beneficiary: \_\_\_\_\_  
If represented by an attorney, please print his or her name here: \_\_\_\_\_  
Phone number: \_\_\_\_\_

2. Name of Eligible Surviving Beneficiary (Please print): \_\_\_\_\_  
Social Security number: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Eligible Surviving Beneficiary: \_\_\_\_\_  
If represented by an attorney, please print his or her name here: \_\_\_\_\_  
Phone number: \_\_\_\_\_

3. Name of Eligible Surviving Beneficiary (Please print): \_\_\_\_\_  
Social Security number: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Eligible Surviving Beneficiary: \_\_\_\_\_  
If represented by an attorney, please print his or her name here: \_\_\_\_\_  
Phone number: \_\_\_\_\_

4. Name of Eligible Surviving Beneficiary (Please print): \_\_\_\_\_  
Social Security number: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Eligible Surviving Beneficiary: \_\_\_\_\_  
If represented by an attorney, please print his or her name here: \_\_\_\_\_  
Phone number: \_\_\_\_\_

*If there are other children filing on behalf of the claimant, please use the back of this page or attach another sheet with the information requested above and their signature and check here.*

**Civil Penalty for Presenting a Fraudulent Claim or Making False Statements or Using False Records:** The declarant shall forfeit and pay to the United States the sum of \$10,000 plus treble the amount of damages sustained by the United States. (See 31 U.S.C. Section 3729).

**Criminal Penalty for Presenting a Fraudulent Claim or Making False Statements:** Fine and imprisonment for not more than 5 years. (See 18 U.S.C. Sections 287 and 1001).

The authority for the collection of this information is the Radiation Exposure Compensation Act of 1990, 42 U.S.C. § 2210 note. The information you provide will be used to verify your identity, to verify your eligibility, and to verify any previous payments made in connection with the compensable disease you identified in Part 10 of the claim form. Some or all of the information you provide may be released to federal, state, and local government agencies or private organization for the purpose of confirming your identity, your eligibility, and any previous payments made in connection with the compensable disease. The information may also be released when otherwise authorized by statute or regulation. Disclosure of the information by you is voluntary; however, it may not be possible to process your claim without the information.

## **MEDICAL RECORDS ATTACHMENT**

Listed below are the specified compensable diseases and the records which the RECA Program shall accept as proof that the person who became ill had the specified compensable disease.

Tear off this attachment and take it to the doctor or hospital holding the records of the person who became ill with one of the specified compensable diseases listed below.

Show this list to the doctor or hospital and ask them to give you original or certified copies of one or more of the records listed below. Select the record(s) containing a diagnosis of the disease, if possible. Otherwise, send the records listed below that are available. If you have questions, call the Radiation Exposure Compensation Program at 1-800-729-7327.

### **(1) Any Leukemia.**

- (i) Bone marrow biopsy or aspirate report;
- (ii) Peripheral white blood cell differential count report;
- (iii) Autopsy report;
- (iv) Hospital discharge summary;
- (v) Physician summary;
- (vi) History and physical report;
- (vii) Death certificate, provided that it is signed by a physician at the time of death

### **(2) Multiple Myeloma.**

- (i) Pathology report of tissue biopsy;
- (ii) Autopsy report;
- (iii) Report of serum electrophoresis;
- (iv) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Hematology summary or consultation report;
  - (D) Medical oncology summary or consultation report;
  - (E) X-ray report;
- (v) Death certificate, provided that it is signed by a physician at the time of death.

### **(3) Lymphoma, other than Hodgkin's disease.**

- (i) Pathology report of tissue biopsy;
- (ii) Autopsy report;
- (iii) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Hematology consultation or summary report;
  - (D) Medical oncology consultation or summary report;
- (iv) Death certificate, provided that it is signed by a physician at the time of death.

### **(4) Primary cancer of the thyroid.**

- (i) Pathology report of tissue biopsy or fine needle aspirate;

- (ii) Autopsy report;
- (iii) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary;
  - (C) Operative summary report;
  - (D) Medical oncology summary or consultation report;
- (iv) Death certificate, provided that it is signed by a physician at the time of death.

**(5) Primary cancer of the male or female breast.**

- (i) Pathology report of tissue biopsy or surgical resection;
- (ii) Autopsy report;
- (iii) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary;
  - (C) Operative report;
  - (D) Medical oncology summary or consultation report;
  - (E) Radiotherapy summary or consultation report;
- (iv) Report of mammogram;
- (v) Report of bone scan;
- (vi) Death certificate, provided that it is signed by a physician at the time of death.

**(6) Primary cancer of the esophagus.**

- (i) Pathology report of tissue biopsy or surgical resection;
- (ii) Autopsy report;
- (iii) Endoscopy report;
- (iv) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Operative report;
  - (D) Radiotherapy report;
  - (E) Medical oncology consultation or summary report;
- (v) One of the following radiological studies:
  - (A) Esophagram;
  - (B) Barium swallow;
  - (C) Upper gastrointestinal (GI) series;
  - (D) Computerized tomography (CT) scan;
  - (E) Magnetic resonance imaging (MRI);
- (vi) Death certificate, provided that it is signed by a physician at the time of death.

**(7) Primary cancer of the stomach.**

- (i) Pathology report of tissue biopsy or surgical resection;
- (ii) Autopsy report;
- (iii) Endoscopy or gastroscopy report;
- (iv) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Operative report;
  - (D) Radiotherapy report;
  - (E) Medical oncology summary report;

- (v) One of the following radiological studies:
  - (A) Barium swallow;
  - (B) Upper gastrointestinal (GI) series;
  - (C) Computerized tomography (CT) series;
  - (D) Magnetic resonance imaging (MRI);
- (vi) Death certificate, provided that it is signed by a physician at the time of death.

**(8) Primary cancer of the pharynx.**

- (i) Pathology report of tissue biopsy or surgical resection;
- (ii) Autopsy report;
- (iii) Endoscopy report;
- (iv) One of the following summary medical reports:
  - (A) Physician summary;
  - (B) Hospital discharge summary;
  - (C) Report of otolaryngology examination;
  - (D) Radiotherapy summary report;
  - (E) Medical oncology summary report;
  - (F) Operative report;
- (v) Report of one of the following radiological studies:
  - (A) Laryngograms;
  - (B) Tomograms of soft tissue and lateral radiographs;
  - (C) Computerized tomography (CT) scan;
  - (D) Magnetic resonance imaging (MRI);
- (vi) Death certificate, provided that it is signed by a physician at the time of death.

**(9) Primary cancer of the small intestine.**

- (i) Pathology report of tissue biopsy;
- (ii) Autopsy report;
- (iii) Endoscopy report, provided the examination covered the duodenum and parts of the jejunum;
- (iv) Colonoscopy report, providing the examination covered the distal ileum;
- (v) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary;
  - (C) Report of gastroenterology examination;
  - (D) Operative report;
  - (E) Radiotherapy summary report;
  - (F) Medical oncology summary or consultation report;
- (vi) Report of one of the following radiologic studies:
  - (A) Upper gastrointestinal (GI) series with small bowel follow-through;
  - (B) Angiography;
  - (C) Computerized tomography (CT) scan;
  - (D) Magnetic resonance imaging (MRI);
- (vii) Death certificate, provided that it is signed by a physician at the time of death.

**(10) Primary cancer of the pancreas.**

- (i) Pathology report of tissue biopsy or fine needle aspirate;
- (ii) Autopsy report;
- (iii) One of the following summary medical reports:

- (A) Physician summary report;
- (B) Hospital discharge summary report;
- (C) Radiotherapy summary report;
- (D) Medical oncology summary report;
- (iv) Report of one of the following radiographic studies:
  - (A) Endoscopic retrograde cholangiopancreatography (ERCP);
  - (B) Upper gastrointestinal (GI) series;
  - (C) Arteriography of the pancreas;
  - (D) Ultrasonography;
  - (E) Computerized tomography (CT) scan;
  - (F) Magnetic resonance imaging (MRI);
- (v) Death certificate, provided that it is signed by a physician at the time of death.

**(11) Primary cancer of the bile ducts.**

- (i) Pathology of tissue biopsy or surgical resection;
- (ii) Autopsy report;
- (iii) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Operative report;
  - (D) Gastroenterology consultation report;
  - (E) Medical oncology summary or consultation report;
- (iv) Report of one of the following radiographic studies:
  - (A) Ultrasonography;
  - (B) Endoscopic retrograde cholangiography;
  - (C) Percutaneous cholangiography;
  - (D) Computerized tomography (CT) scan;
- (v) Death certificate, provided that it is signed by a physician at the time of death.

**(12) Primary cancer of the gall bladder.**

- (i) Pathology report of tissue from surgical resection;
- (ii) Autopsy report;
- (iii) Report of one of the following radiological studies:
  - (A) Computerized tomography (CT) scan;
  - (B) Magnetic resonance imaging (MRI);
  - (C) Ultrasonography (ultrasound);
- (iv) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Operative report;
  - (D) Radiotherapy report;
  - (E) Medical oncology summary or report;
- (v) Death certificate, provided that it is signed by a physician at the time of death.

**(13) Primary cancer of the salivary gland.**

- (i) Pathology report of tissue biopsy or resection;
- (ii) Autopsy report;
- (iii) Report of otolaryngology or oral maxillofacial examination;
- (iv) One of the following summary medical reports:

- (A) Physician summary report;
- (B) Hospital discharge summary report;
- (C) Radiotherapy summary report;
- (D) Medical oncology summary report;
- (E) Operative report;
- (v) Report of one of the following radiology examinations:
  - (A) Computerized tomography (CT) scan;
  - (B) Magnetic resonance imaging (MRI);
- (vi) Death certificate, provided that it is signed by a physician at the time of death.

**(14) Primary cancer of the urinary bladder.**

- (i) Pathology report of tissue biopsy or resection;
- (ii) Autopsy report;
- (iii) Report of cystoscopy, with or without biopsy;
- (iv) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Radiotherapy summary report;
  - (D) Medical oncology summary report;
  - (E) Operative report;
- (v) Report of one of the following radiology examinations:
  - (A) Computerized tomography (CT) scan;
  - (B) Magnetic resonance imaging (MRI);
- (vi) Death certificate, provided that it is signed by a physician at the time of death.

**(15) Primary cancer of the brain.**

- (i) Pathology report of tissue biopsy or resection;
- (ii) Autopsy report;
- (iii) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Radiotherapy summary report;
  - (D) Medical oncology summary report;
  - (E) Operative report;
- (iv) Report of one of the following radiology examinations:
  - (A) Computerized tomography (CT) scan;
  - (B) Magnetic resonance imaging (MRI);
  - (C) CT or MRI with enhancement
- (v) Death certificate, provided that it is signed by a physician at the time of death.

**(16) Primary cancer of the colon.**

- (i) Pathology report of tissue biopsy;
- (ii) Autopsy report;
- (iii) Endoscopy report, provided the examination covered the duodenum and parts of the jejunum;
- (iv) Colonoscopy report, providing the examination covered the distal ileum;
- (v) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary;

- (C) Report of gastroenterology examination;
- (D) Operative report;
- (E) Radiotherapy summary report;
- (F) Medical oncology summary or consultation report;
- (vi) Report of one of the following radiologic studies:
  - (A) Upper gastrointestinal (GI) series with small bowel follow-through;
  - (B) Angiography;
  - (C) Computerized tomography (CT) scan;
  - (D) Magnetic resonance imaging (MRI);
- (vii) Death certificate, provided that it is signed by a physician at the time of death.

**(17) Primary cancer of the ovary.**

- (i) Pathology report of tissue biopsy or resection;
- (ii) Autopsy report;
- (iii) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Radiotherapy summary report;
  - (D) Medical oncology summary report;
  - (E) Operative report;
- (iv) Death certificate, provided that it is signed by a physician at the time of death.

**(18) Primary cancer of the bone.**

- (i) Pathology report of tissue biopsy or resection;
- (ii) Autopsy report;
- (iii) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Radiotherapy summary report;
  - (D) Medical oncology summary report;
  - (E) Operative report;
- (iv) Report of one of the following radiology examinations:
  - (A) Computerized tomography (CT) scan;
  - (B) Magnetic resonance imaging (MRI);
- (v) Death certificate, provided that it is signed by a physician at the time of death.

**(19) Primary renal cancer.**

- (i) Pathology report of tissue biopsy or resection;
- (ii) Autopsy report;
- (iii) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Radiotherapy summary report;
  - (D) Medical oncology summary report or consultation report;
  - (E) Operative report;
- (iv) Report one of the following radiology examinations:
  - i. Computerized tomography (CT) scan;
  - ii. Magnetic resonance imaging (MRI); or

- (v) Death certificate, provided that it is signed by a physician at the time of death.

**(20) Primary cancer of the liver (except if cirrhosis or hepatitis B is indicated).**

- (i) Pathology report of tissue biopsy or surgical resection;
- (ii) Autopsy report;
- (iii) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Medical oncology summary report;
  - (D) Operative report;
  - (E) Gastroenterology report;
- (iv) Report of one of the following radiological studies:
  - (A) Computerized tomography (CT) scan;
  - (B) Magnetic resonance imaging (MRI);
- (v) Death certificate, provided that it is signed by a physician at the time of death.

**(21) Primary cancer of the lung.**

- (i) Pathology report of tissue biopsy or resection, including, but not limited to specimens obtained by any of the following methods:
  - (A) Surgical resection;
  - (B) Endoscopic endobronchial or transbronchial biopsy;
  - (C) Bronchial brushings and washings;
  - (D) Pleural fluid cytology;
  - (E) Fine needle aspirate;
  - (F) Pleural biopsy;
  - (G) Sputum cytology;
- (ii) Autopsy report;
- (iii) Report of bronchoscopy, with or without biopsy;
- (iv) One of the following summary medical reports:
  - (A) Physician summary report;
  - (B) Hospital discharge summary report;
  - (C) Radiotherapy summary report;
  - (D) Medical oncology summary report;
  - (E) Operative report;
- (v) Report of one of the following radiology examinations:
  - (A) Computerized tomography (CT) scan;
  - (B) Magnetic resonance imaging (MRI);
  - (C) X-rays of the chest;
  - (D) Chest tomograms;
- (vi) Death certificate, provided that it is signed by a physician at the time of death.