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.**

- ☑ Form 1 - Intake Form*
- ☑ Form 2 – Medical Assessment Form
- ☑ 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 requested 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.
- **This documentation will be collected by VISP directly from relevant health care providers.**
- 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).

DO NOT PROVIDE ANY MEDICAL RECORDS BEYOND THE REQUESTED DOCUMENTS IN STEP 1.

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 ONLY 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
340 Albert St. Suite 1800
Ottawa, Ontario
K1R 7Y6

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

Intake Form

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).

1 IDENTIFICATION AND CONTACT INFORMATION OF THE INDIVIDUAL SUBMITTING THE CLAIM

Note: please select all options that apply.

Identity of the individual submitting the claim	___ Injured Party	The individual who received a Health Canada authorized vaccine, administered in Canada, on or after December 8, 2020.
	___ Beneficiary	The beneficiary is the individual who is determined to be eligible and would ultimately receive financial support. The beneficiary can be the injured party, or in the cases where the injured party is deceased; the beneficiary may be a family member of the injured party (ex. spouse, children, dependent, etc.).
	___ Authorized Representative	The authorized representative is an individual authorized to complete the claim on behalf of either the beneficiary or injured party. (if applicable, please complete Appendix A).

2 IDENTIFICATION AND CONTACT INFORMATION OF THE INJURED PARTY

Note: all information is required to be completed, unless otherwise specified.

Surname (last name)	**Given name(s)**

Residential address

Number/Street (include apt # if applicable) | City | Prov/Terr. | Country | Postal Code

Mailing address (if different from current residential address) Check if the same as above

Number/Street (include apt # if applicable) | City | Prov/Terr. | Country | Postal Code

Email address	**Primary telephone**	**Secondary telephone (if applicable)**

Date of birth	**Sex**	**Preferred language**
(YYYY-MM-DD)		☐ English ☐ French

Note: please complete the following information if you selected ONLY beneficiary.

Surname (last name)	**Given name(s)**

Relationship to injured party	**Preferred language**
(Spouse, Father, Mother, Child, Legal Guardian, etc.)	☐ English ☐ French

Mailing address

Number/Street (include apt # if applicable) | City | Prov/Terr. | Country | Postal Code

Email address	Primary telephone	Secondary telephone (if applicable)

3 RELEVANT DETAILS PERTAINING TO THE VACCINE INJURY

VACCINE ADMINISTRATION

Note: all information is required to be completed, unless otherwise specified.

Date of vaccination	Location where vaccination occurred	Province or Territory where vaccination occurred
(YYYY-MM-DD)	(private doctor office, hospital etc.)	Province or Territory

Name of the individual who administered the vaccine (if known)

Manufacturer name (if known)	Date symptoms first appeared
(ex. Pfizer, GlaxoSmithKline, Sanofi Pasteur etc.)	(YYYY-MM-DD)

Disease associated to the vaccine (this is required for an assessment of causality of the diagnosed injury)

Disease/Injury diagnosed:

Is the injury serious and permanent? (See definition on the right)	Serious and Permanent Severe, life-threatening or life-altering injury that may require in-person hospitalization, or a prolongation of existing hospitalization, and results in persistent or significant disability or incapacity, or where the outcome is a congenital malformation or death.
☐ Yes ☐ No	

FIRST MEDICAL CONSULTATION

Note: all information is required to be completed, unless otherwise specified.

Date of first medical consultation	Location of first medical consultation
(YYYY-MM-DD)	(private doctor office, hospital etc.)
Name of medical professional 1	**Primary telephone**

ADDITIONAL MEDICAL CONSULTATION(S)

Note: all information is required to be completed, unless otherwise specified.

Name of medical professional 2 (if applicable)	Location	Primary telephone
	(private doctor office, hospital etc.)	
Name of medical professional 3 (if applicable)	**Location**	**Primary telephone**
	(private doctor office, hospital etc.)	

Identification of the hospital(s) or clinic(s) providing care after the vaccination:

Description of the symptoms of adverse effects and/or injuries following vaccination

4 IDENTIFICATION OF THE INJURED PARTY'S USUAL ATTENDING PHYSICIAN OR FAMILY PHYSICIAN

Note: if the Injured Party does not have a usual attending physician or family physician skip this section.

Name of physician:

Hospital / clinic name:

Location

Number/Street (include apt # if applicable) | City | Prov/Terr. | Country | Postal Code

Contact Information

Primary telephone

Secondary telephone (if applicable)

5 COMMENTS

Note: if no additional comments, skip this section.

Other Comments:

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 declare that all the information provided above is true and completed to the best of my knowledge.

Signature of the Injured Party or the Injured Party's Authorized Representative

Date

YYYY-MM-DD

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

Mail: Vaccine Injury Support Program
340 Albert St., Suite 1800
Ottawa, Ontario
K1R 7Y6

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

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 completed, unless otherwise specified.

Surname (last name)	**Given name(s)**

Date of Birth

(YYYY-MM-DD)

Status of Injured Party Minor Deceased Other (Please Specify)

2 AUTHORIZED REPRESENTATIVE INFORMATION

Note: all information is required to be completed, unless otherwise specified.

Surname (last name)	**Given name(s)**

Relationship to injured party	**Preferred language**
(Spouse, Father, Mother, Child, Legal Guardian, etc.)	English French

If the injury party is deceased, are you authorized to give consent for collection of medical records?

☐ **Yes** ☐ **No** (If no, you cannot act as an authorized representative as we will be unable to collect medical records)

Address

Number/Street (include apt # if applicable)	City	Prov/Terr.	Country	Postal Code

Email address	**Primary telephone**	**Secondary telephone (if applicable)**

3 IDENTIFICATION OF BENEFICIARY (IF DIFFERENT FROM INJURED PARTY OR AUTHORIZED REPRESENTATIVE)

Note: The beneficiary is the individual who is determined to be eligible and would ultimately receive financial support. All information is required to be completed, unless otherwise specified.

Surname (last name)	**Given name(s)**

Relationship to injured party	**Preferred language**
(Spouse, Father, Mother, Child, Legal Guardian, etc.)	English 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.

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-DD
Signature of Authorized Representative	**Date**
	YYYY-MM-DD
Signature of Beneficiary (if different from the Injured Party or the Authorized Representative)	**Date**
	YYYY-MM-DD

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

Mail: Vaccine Injury Support Program
340 Albert St., Suite 1800
Ottawa, Ontario
K1R 7Y6

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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, unless otherwise specified.

Physician's surname (last name)	**Physician's given name(s)**

Primary address (of clinic/hospital/practice)

Number/Street (include apt # if applicable)	City	Prov/Terr.	Country	Postal Code

Mailing address (if different from above) Check if the same as above

Number/Street (include unit # if applicable)	City	Prov./Terr.	Country	Postal Code

Email address	**Primary telephone**	**Secondary telephone (if applicable)**

Medical license number or licensed practice number	**Preferred language**
	English French

2 PATIENT (INJURED PARTY) INFORMATION

Note: All information is required to be completed, unless otherwise specified.

Patient's surname (last name)	**Patient's given name(s)**

Date of birth

YYYY-MM-DD

3 RELEVANT DETAILS PERTAINING TO THE VACCINE INJURY

Note: All information is required to be completed, unless otherwise specified.

Date and time of vaccination	**Location where vaccination occurred**	**Province or Territory where vaccination occurred**
(YYYY-MM-DD) – (HH:MM AM/PM)	(private doctor office, hospital etc.)	Province or Territory

Vaccine name and/or Immunity against which disease (e.g., COVID-19, Measles, HPV, etc.)	**Name of the individual who administered the vaccine (if known)**

Batch/lot number (if known)	**Expiry date (if known)**	**Dose number (1st, 2nd, etc.) (if known)**
	(YYYY-MM-DD)	

Manufacturer name(s) (if known)	**Date symptoms first appeared**
(e.g., Pfizer, GlaxoSmithKline, Sanofi Pasteur etc.)	(YYYY-MM-DD)

Please list the name of the vaccine injury diagnosis (this is required in order to assess the diagnosed injury):	
Injury Diagnosis:	
Is the Injury serious and permanent? **(See definition on the right)** ☐ Yes ☐ No	**Serious and Permanent -** Severe, life-threatening or life-altering injury that may require in-person hospitalization, or a prolongation of existing hospitalization, and results in persistent or significant disability or incapacity, or where the outcome is a congenital malformation or death**.**
Patient status: ☐ Deceased ☐ Recovered ☐ Unknown ☐ Recovering ☐ Other:_____	**If deceased, was an autopsy done? (Complete if yes, or write future date if an autopsy is planned)** (YYYY-MM-DD)

Description of adverse effects and/or injuries following vaccination (initial and persistent) and Medical Diagnosis:

FIRST MEDICAL CONSULTATION
Note: all information is required to be completed, unless otherwise specified.

Date of first medical consultation	**Location of first medical consultation**
(YYYY-MM-DD)	(Private doctor office, hospital etc.)
Name of medical professional 1	**Primary telephone**

ADDITIONAL MEDICAL CONSULTATION(S)
Note: all information is required to be completed, unless otherwise specified.

Name of medical professional 2	**Location**	**Primary telephone**
	(Private doctor office, hospital etc.)	
Name of medical professional 3	**Location**	**Primary telephone**
	(Private doctor office, hospital etc.)	

Identification of the hospital(s) or clinic(s) providing care after the vaccination:

Adverse Events Following Immunization (AEFI) Report
If an AEFI report been submitted regarding this injury, please include a copy with this Medical Assessment Form.

4 PATIENT MEDICAL HISTORY

Note: all information is required to be completed, unless otherwise specified.

Have you ever examined or treated this patient before the onset of the injury and/or disease potentially related to the vaccination?	**Yes**	**No**
Is there any relevant medical history or a cumulative patient profile (CPP)? Check no, if not applicable.	**Yes**	**No**

Please complete the following table:

Criteria	**Finding**	**Remarks (If yes, provide details)**
History of similar events	Yes No Unknown	
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	
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) No Unknown

Currently Breastfeeding? Yes No

For infants:

The birth was: Full-term Pre-term Post-term Birth Weight: (lbs), (oz)

Delivery: Normal Cesarean Assistedvacuum, etc.) Complications (Specify):

Additional Comments

NOTE - Specifics on adverse effects and/or injuries following vaccination will be completed above and do not need to be added here.

5 COMMENTS

Note: if no additional comments, skip this section.

Other Comments:

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

By signing this form, I declare that all information provided above is true and completed to the best of my knowledge.

Signature of the physician

Physician Signature

Date (YYYY-MM-DD)

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

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