

## 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).

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

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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](http://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  
116 Albert St. Suite 1000  
Ottawa, Ontario  
K1P 5G3

For more information, please contact us by phone: 1-833-489-0839, email: [info@vaccineinjurysupport.ca](mailto:info@vaccineinjurysupport.ca) or visit our website: [www.vaccineinjurysupport.ca](http://www.vaccineinjurysupport.ca)

# Intake Form (Form 1)

## 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				
<b>Note: please select all options that apply.</b>				
<b>Identity of the individual submitting the claim</b>	<input type="checkbox"/> Injured Party	The individual who received a Health Canada authorized vaccine, administered in Canada, on or after December 8, 2020.		
	<input type="checkbox"/> 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.).		
	<input type="checkbox"/> 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).		
<b>Note: please complete the following information if you selected ONLY beneficiary.</b>				
Surname (last name)		Given name(s)		
Relationship to injured party				Preferred language
(Spouse, Father, Mother, Child, Legal Guardian, etc.)				<input type="checkbox"/> English <input type="checkbox"/> French
Mailing address				
Number/Street (include apt # if applicable)	City	Prov/Terr.	Country	Postal Code
Email address	Primary telephone		Secondary telephone (if applicable)	
2 IDENTIFICATION AND CONTACT INFORMATION OF THE INJURED PARTY				
<b>Note: all information is required to be completed, unless otherwise specified.</b>				
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) <input type="checkbox"/> 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)	

**Place of birth**

City	Prov./Terr. (if applicable)	Country
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<b>Date of birth</b>  (YYYY-MM-DD)	<b>Sex</b>  	<b>Preferred language</b> <input type="checkbox"/> English <input type="checkbox"/> French
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**3 RELEVANT DETAILS PERTAINING TO THE VACCINE INJURY**
**VACCINE ADMINISTRATION**
**Note: all information is required to be completed, unless otherwise specified.**

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

<b>Vaccine name and/or Immunity against which disease</b> (e.g., COVID-19, Measles, HPV, etc.)	<b>Name of the individual who administered the vaccine (if known)</b>  
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<b>Manufacturer name (if known)</b>  (e.g., Pfizer, GlaxoSmithKline, Sanofi Pasteur etc.)	<b>Date symptoms first appeared</b>  (YYYY-MM-DD)
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**FIRST MEDICAL CONSULTATION**
**Note: all information is required to be completed, unless otherwise specified.**

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

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

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

**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:

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K1P 5G3

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# 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				
<b>Note: all information is required to be completed, unless otherwise specified.</b>				
Surname (last name)		Given name(s)		
<hr/>		<hr/>		
Date of Birth <small>(YYYY-MM-DD)</small>				
<hr/>				
Status of Injured Party <input type="checkbox"/> Minor <input type="checkbox"/> Deceased <input type="checkbox"/> Other (Please Specify) <hr/>				
2 AUTHORIZED REPRESENTATIVE INFORMATION				
<b>Note: all information is required to be completed, unless otherwise specified.</b>				
Surname (last name)		Given name(s)		
<hr/>		<hr/>		
Relationship to injured party			Preferred language	
<hr/>			<input type="checkbox"/> English	
<small>(Spouse, Father, Mother, Child, Legal Guardian, etc.)</small>			<input type="checkbox"/> French	
Address				
<hr/>				
Number/Street (include apt # if applicable)	City	Prov/Terr.	Country	Postal Code
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Email address		Primary telephone		Secondary telephone (if applicable)
<hr/>		<hr/>		<hr/>
3 IDENTIFICATION OF BENEFICIARY (IF DIFFERENT FROM INJURED PARTY OR AUTHORIZED REPRESENTATIVE)				
<b>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.</b>				
Surname (last name)		Given name(s)		
<hr/>		<hr/>		
Relationship to injured party			Preferred language	
<hr/>			<input type="checkbox"/> English	
<small>(Spouse, Father, Mother, Child, Legal Guardian, etc.)</small>			<input type="checkbox"/> 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.

**PROTECTED B** (when completed)

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**

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YYYY-MM-DD

**Signature of Authorized Representative****Date**

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YYYY-MM-DD

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

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YYYY-MM-DD

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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				
<b>Note: All information is required to be completed, unless otherwise specified.</b>				
Physician's surname (last name) <hr/>		Physician's given name(s) <hr/>		
Primary address (of clinic/hospital/practice) <hr/>				
Number/Street (include apt # if applicable) <hr/>	City <hr/>	Prov./Terr. <hr/>	Country <hr/>	Postal Code <hr/>
Mailing address (if different from above) <input type="checkbox"/> Check if the same as above				
Number/Street (include unit # if applicable) <hr/>	City <hr/>	Prov./Terr. <hr/>	Country <hr/>	Postal Code <hr/>
Email address <hr/>	Primary telephone <hr/>		Secondary telephone (if applicable) <hr/>	
Medical license number or licensed practice number <hr/>				Preferred language <input type="checkbox"/> English <input type="checkbox"/> French
2 PATIENT (INJURED PARTY) INFORMATION				
<b>Note: All information is required to be completed, unless otherwise specified.</b>				
Patient's surname (last name) <hr/>		Patient's given name(s) <hr/>		
Date of birth <hr/>				
YYYY-MM-DD				
3 RELEVANT DETAILS PERTAINING TO THE VACCINE INJURY				
<b>Note: All information is required to be completed, unless otherwise specified.</b>				
Date and time of vaccination <hr/>	Location where vaccination occurred <hr/>	Province or Territory where vaccination occurred <hr/>		
(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.) <hr/>		Name of the individual who administered the vaccine (if known) <hr/>		
Batch/lot number (if known) <hr/>	Expiry date (if known) <hr/>		Dose number (1 <sup>st</sup> , 2 <sup>nd</sup> , etc.) (if known) <hr/>	
(YYYY-MM-DD)				
Manufacturer name(s) (if known) <hr/>			Date symptoms first appeared <hr/>	
(e.g., Pfizer, GlaxoSmithKline, Sanofi Pasteur etc.)			(YYYY-MM-DD)	





**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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Adverse events following immunization (AEFI) (vaccination)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
History of allergy to vaccine, drug, or food	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Pre-existing illness (30 days)/congenital	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
History of hospitalization in the last 30 days, with cause	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Patient currently on concomitant medication? (If yes, name drug, indication, doses, and treatment dates)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Family history of any disease (relevant to AEFI) or allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 ☐ Assisted (forceps, vacuum, 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)

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