U.S. Department of Justice
Civil Division

Radiation Exposure Compensation Program
"Interim" Uranium Mine Employee Claim Form

Interim claim form for cases filed after enactment of the Radiation Exposure Compensation Act Amendments of 2000 where an individual was exposed to radiation while working in ***above-ground or underground*** *uranium mines and later developed lung cancer or a nonmalignant respiratory disease. A claimant or persons seeking compensation on behalf of a claimant (if claimant is deceased) may apply.*

INSTRUCTIONS:
Complete all Parts of the white "Interim" Uranium Mine Employee Claim Form and all Parts (except Parts 4, 6, and 7) of the attached pink "Uranium Mine Employee" Form.
Contact the Radiation Exposure Compensation Program for additional help at 1-800-729-7327.

Part A This section replaces Part 4 of the pink "Uranium Mine Employee" Form. Part A concerns information about the DISEASE that the claimant developed after employment in an above-ground or underground uranium mine.

- Place a check next to the DISEASE that the claimant developed.
- If the claimant did NOT become ill with one of the listed diseases, he or she is not eligible for compensation.

_____ lung cancer (including any physiological condition of the lung, trachea, or bronchus that is recognized as "lung cancer")
_____pulmonary fibrosis
_____fibrosis of the lung
_____silicosis
_____ cor pulmonale related to fibrosis of the lung
_____ pneumoconiosis

Part B This section replaces Part 6 of the pink "Uranium Mine Employee" Form. Part B concerns information about the claimant's uranium mine employment history.

- Fill in the following chart with as much of the work history of the claimant as you know beginning with the earliest period of employment and continuing chronologically until the last period of employment.
  Check here ___ if you would like the Radiation Program to help you reconstruct this employment history. We will call to help you after we receive this form.

- Provide as many records as you now have which show that the claimant worked in the uranium mines you listed on the chart. Send original or certified copies of these records unless you cannot obtain original or certified copies. If you cannot obtain original or certified copies, send the records you have and attach a short note explaining why you cannot obtain original or certified copies.
  Check here ___ if you would like the Radiation Program to help you obtain records showing employment in an above-ground or underground uranium mine.

Name of Employer	Name of Mine	Name of Mining Area	County and State	Dates Worked (Month/Yr-Month/Yr)	Occupation or Activity in Mine	Designate Above-Ground or Underground Mining	Identify and Attach Any Records Which Reflect Each Period of Employment

Part C This section replaces Part 7 of the pink "Uranium Mine Employee" Form. Part C concerns information about the LEVEL OF RADIATION to which the claimant was exposed while working in above-ground or underground uranium mines.

- If you have any records containing this information, send original or certified copies of these records. If you cannot obtain original or certified copies, send the records you have and attach a short note explaining why you cannot obtain the original or certified copies.
- If the claimant participated in one of the uranium miner studies listed below, place a check next to the appropriate uranium miner study.
  _____ Public Health Service (PHS) Study of Uranium Miners
  _____ St. Mary's Hospital Study of Uranium Miners
  _____ University of New Mexico School of Medicine/Tumor Registry Study of Uranium Miners
  _____ Do not know, but would like the Radiation Program to find out for me.
- If you would like the Radiation Program to obtain documentation from the sources listed above, complete the Authorization to Release to Employment, Medical and Other Information form, attached.

Part D Signature and Date.

I declare under penalty of perjury that the above information is true, correct, and complete to the best of my knowledge and belief.

_____ Date_____

Signature of Claimant or Person Filing on Behalf of Claimant or Legal Guardian

Civil Penalty for Presenting Fraudulent Claim or Making False Statements or Using False Record
The claimant 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. § 3729).

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

You may file a claim by completing the white "Interim" Uranium Mine Employee Claim Form and the attached pink "Uranium Mine Employee" Form (except Parts 4, 6, and 7) and mailing them to:

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

U.S. Department of Justice
Civil Division

Radiation Exposure Compensation Program
"Uranium Mine Employee" Form

Claim form for cases where a person was exposed to radiation while working in a uranium mine and later developed lung cancer or a nonmalignant respiratory disease listed in Part 4 of this form.

- Complete each of the Parts of this form.
- Refer to the Pink Guidebook for help.
- Contact the Radiation Exposure Compensation Unit for additional help at 1-800-729-RECP.

Part 1

- This Part concerns information about YOU - THE PERSON FILING THIS CLAIM.
- Fill in the spaces below.
- Attach an original or certified copy of your birth certificate.
- If you are the legal guardian of the person eligible to file this claim, check here ☐ and fill in the spaces below with information about the person on whose behalf you are filing. Fill in the information requested in Part 9 regarding the name and address of the legal guardian.

First name

Middle name

Last name

Other names (e.g., maiden, name change, etc.)

Mailing address

Zip code

Residence address (if different from mailing address)

Phone number (day) – –

Phone number (evening) – –

Social security number – –

Date of Birth (month/day/year)

Place of birth (city, county, state)

- ☐ Check here if you are a member of an Indian Tribe.
- Print the name of your Tribe and census number here: _____

_____

- If you are a member of an Indian Tribe, you do not need to provide the records requested in this Part or in Parts 2 and 3 of this form at this time. We will contact the Vital Statistics Office of your Tribe and obtain the necessary records for you.

Part 2

- This Part concerns information about the PERSON WHO BECAME ILL WITH LUNG CANCER OR A NONMALIGNANT RESPIRATORY DISEASE.
- ☐ Check here if YOU -- THE PERSON FILING THIS CLAIM -- are the person who became ill with lung cancer or a malignant respiratory disease. Go to Part 3.
- If you are not the person who became ill, fill in the spaces below.
- Attach an original or certified copy of the person's birth certificate and death certificate.

First name

Middle name

Last name

Other names (e.g., maiden, name change, etc.)

Social security number

Date of Birth (month/day/year)

Date of Death (month/day/year)

Place of birth (city, county, state)

Place of death (city, county, state)

Part 3

- This Part concerns information about your RELATIONSHIP with the person you identified in Part 2 of this form as having lung cancer or a nonmalignant respiratory disease.
- Select the relationship that YOU – THE PERSON FILING THIS CLAIM – had with the person who became ill with lung cancer or a nonmalignant respiratory disease (the person identified in Part 2 of this form):

  SELF – go to Subpart (a)
  SPOUSE – go to Subpart (b)
  CHILD – go to Subpart (c)
  PARENT – go to Subpart (d)
  GRANDCHILD – go to Subpart (e)
  GRANDPARENT – go to Subpart (f)

a. ☐ Check here if YOU – THE PERSON FILING THIS CLAIM – are the person identified in Part 2 who became ill with lung cancer or a nonmalignant respiratory disease. Go to Part 4, now.

b. ☐ SPOUSE. Check here if you are filing this claim as the SPOUSE of the person identified in Part 2 who became ill with lung cancer or a nonmalignant respiratory disease. Please answer the following questions. Go to Part 4 after you have answered these questions.

Yes ☐ No ☐ Is the person identified in Part 2 deceased? If "NO", you are not eligible to file this claim. Please consult your Guidebook.

Yes ☐ No ☐ Were you married to the person identified in Part 2 for at least one year immediately prior to that person's death? If "NO", you are not eligible to file this claim. Please consult your Guidebook. If "YES", attach an original or certified copy of your marriage certificate.

c. ☐ CHILD. Check here if you are filing as a CHILD of the person identified in Part 2 who became ill with lung cancer or a nonmalignant respiratory disease. Please answer the following questions. Go to Part 4 after you have answered the questions.

Yes ☐ No ☐ Is the person identified in Part 2 deceased? If "NO", you are not eligible to file this claim. Please consult your Guidebook.

Yes ☐ No ☐ Was the person identified in Part 2 ever married? If "YES", list the name of each spouse, the date and place each marriage began and ended, and the date and place of divorce or death of the last spouse of the person identified in Part 2. Attach an original or certified copy of the marriage certificate and the death certificate or divorce decree for each spouse of the person identified in Part 2.

_____

_____

_____

_____

Use a separate sheet of paper if additional space is needed.

Yes ☐ No ☐ Are you a natural child of the person identified in Part 2?

Yes ☐ No ☐ Are you an adopted child of the person identified in Part 2? If "YES", attach an original or certified copy of the judicial decree of adoption.

Yes ☐ No ☐ Are you a step-child who lived in a regular parent-child relationship with the person identified in Part 2? If "YES", attach original or certified copies of records (e.g., school records) indicating that you lived with the person identified in Part 2 in a regular parent-child relationship.

Yes ☐ No ☐ Were there any other natural, adopted, or step-children of the person identified in Part 2 other than you? If "YES", list the name of each child, the date and place of birth of each child, and the date and place of death or current address of each child. Attach an original or certified copy of the death certificate for each deceased child.

_____

_____

_____

_____

_____

Use a separate sheet of paper if additional space is needed.

d. ☐ PARENT. Check here if you are filing as the PARENT of the person identified in Part 2 who became ill with lung cancer or a nonmalignant respiratory disease. Please answer the following questions. Go to Part 4 after you have answered these questions.

Yes ☐ No ☐ Is the person identified in Part 2 deceased? If "NO", you are not eligible to file this claim. Please consult your Guidebook.

Yes ☐ No ☐ Was the person identified in Part 2 ever married? If "YES", list the name of each spouse, the date and place each marriage began and ended, and the date and place of divorce or death of the last spouse of the person identified in Part 2. Attach an original or certified copy of the marriage certificate and the death certificate or divorce decree for each spouse of the person identified in Part 2.

_____

_____

_____

_____

_____

Use a separate sheet of paper if additional space is needed.

Yes ☐ No ☐ Did the person identified in Part 2 have any natural, adopted, or step-children? If "YES", list the name of each child, the date and place of birth of each child (or date and place of adoption), and the date and place of death of each child of the person identified in Part 2. Attach an original or certified copy of the death certificate of each child.

Use a separate sheet of paper if additional space is needed.

Yes ☐ No ☐ Are you a natural father/mother of the person identified in Part 2?

Yes ☐ No ☐ Are you an adoptive father/mother of the person identified in Part 2? If "YES", attach an original or certified copy of the judicial decree of adoption.

Yes ☐ No ☐ Are there any living natural or adoptive parents of the person identified in Part 2 other than you? If "YES", list the name and address of each parent. If "NO", list the name, and date and place of death of each deceased parent. Attach an original and certified copy of the death certificate of each deceased parent.

e. ☐ GRANDCHILD. Check here if you are filing as a GRANDCHILD of the person who became ill with lung cancer or a nonmalignant respiratory disease. A member of the Radiation Exposure Compensation Unit will contact you to provide assistance in establishing your relationship with the person who had lung cancer or a nonmalignant respiratory disease.

f. ☐ GRANDPARENT. Check here if you are filing as a GRANDPARENT of a person who became ill with lung cancer or a nonmalignant respiratory disease. A member of the Radiation Exposure Compensation Unit will contact you to provide assistance in establishing your relationship with the person who had lung cancer or a nonmalignant respiratory disease.

Part 4

- This Part concerns information about the DISEASE that the person identified in Part 2 developed after employment in a uranium mine.
- Place a check in the box next to the DISEASE that developed after employment in a uranium mine.
- If the person identified in Part 2 did NOT become ill with one of the diseases listed on the following page, you are not eligible for compensation. Please consult your Guidebook or contact the Radiation Exposure Compensation Unit.

☐ ~~primary~~ cancer of the lung, trachea or bronchus ☐ moderate or severe pneumoconiosis

☐ pulmonary fibrosis ~~or fibrosis~~ of the lung ☐ ~~cor~~ pulmonale related to fibrosis of the lung

☐ ~~moderate or severe silicosis~~

Part 5

- This Part concerns RECORDS which can prove that the person identified in Part 2 actually became ill with lung cancer or a nonmalignant respiratory disease.
- You must either (1) send us the records listed on the attachment to this form, or (2) in the case of lung cancer permit us to contact the National Institute for Occupatinal Safety and Health (NIOSH), St. Mary's Hospital in Grand Junction, CO, the University of New Mexico School of Medicine, or the appropriate state cancer or tumor registry to confirm eligibility for you.
- Select the method(s) you wish to use to prove that the person identified in Part 2 actually became ill with lung cancer or a nonmalignant respiratory disease:

  ☐ Check here if you are submitting one of the records listed on the Medical Records Attachment.

  ☐ Check here if you want the Radiation Unit to contact NIOSH. Lung cancer **only**.

  ☐ Check here if you want the Radiation Unit to contact St. Mary's Hospital. Lung cancer **only**.

  ☐ Check here if you want the Radiation Unit to contact the University of New Mexico School of Medicine. Lung cancer **only**.

  ☐ Check here if you want the Radiation Unit to contact the state cancer or tumor registry indicated below.

- If the person who became ill with lung cancer was diagnosed as having that disease in any of the following states, please place a check in the box next to the appropriate state:

  ☐ Arizona ☐ New Mexico

  ☐ Colorado ☐ Utah

  ☐ Nevada ☐ Wyoming

- Fill out and return the Authorization to Release Medical and Other Information page **and** the Authorization to Release Mining, Employment, Medical and Other Information page attached to this claim form.

Part 6

- This Part concerns information about the chronological underground uranium mine employment history of the person identified in Part 2.
- Fill in the following chart with as much of the work history of the person identified in Part 2 as you know beginning with the earliest employment in a mine and continuing chronologically until the last period of employment in a mine. Check here ☐ if you would like the Radiation Unit to help you reconstruct this employment history. We will call to help you after we receive this form.
- Provide as many records as you now have which show that the person identified in Part 2 worked in the uranium mines you listed on the chart. Send original or certified copies of these records unless you cannot obtain original or certified copies. If you cannot obtain original or certified copies, send the records you have and attach a short note explaining why you cannot obtain original or certified copies. Check here ☐ if you would like the Radiation Unit to help you obtain records showing employment in uranium mines.
- Fill out the Authorization to Release Mining Employment, Medical and Other Information page attached to this form and return it to the Radiation Unit with the claim form.

	Name of Employer	Name of Mine	Name of Mining Area	County and State	Dates Worked in (Month/Yr-Month/Yr)	Occupation Activity in Mine	Identify and Attach Any Record which Reflects Each Period of Employment
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Name of Employer	Name of Mine	Name of Mining Area	County and State	Dates Worked in (Month/Yr-Month/Yr)	Occupation Activity in Mine	Identify and Attach Any Record which Reflects Each Period of Employment
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

	Name of Employer	Name of Mine	Name of Mining Area	County and State	Dates Worked in (Month/Yr-Month/Yr)	Occupation Activity in Mine	Identify and Attach Any Record which Reflects Each Period of Employment
21.							
22.							
23.							
24.							
25.							
26.							
27.							
28.							
29.							
30.							

Part 7

- This Part concerns information about the LEVEL OF RADIATION to which the person identified in Part 2 was exposed while working in each uranium mine.
- If you have any records containing this information send original or certified copies of these records. If you cannot obtain original or certified copies, send the records you have and attach a short note explaining why you cannot obtain originals or certified copies.
- Check the appropriate box regarding the person who became ill (if known):
  - ☐ Nonsmoker and exposed to at least 200 working level months of radiation;
  - ☐ Smoker diagnosed with lung cancer or a nonmalignant respiratory disease **prior** to age 45 and exposed to at least 300 working level months of radiation;
  - ☐ Smoker diagnosed with lung cancer or a nonmalignant respiratory disease **after** age 45 and exposed to at least 500 working level months of radiation; or
  - ☐ Do not know, but would like the Radiation Unit to help me.
- Check the appropriate box(es) regarding records showing the level of radiation to which the person identified in Part 2 was exposed while working in uranium mines (if known):
  - ☐ Public Health Service Study of Uranium Miners reflects 200 / 300 / 500 working level months of radiation (circle correct number);
  - ☐ St. Mary's Hospital Study of Uranium Miners reflects 200 / 300 / 500 working level months of radiation (circle correct number);
  - ☐ University of New Mexico School of Medicine/Tumor Registry Study of Uranium Miners reflects 200 / 300 / 500 working level months of radiation (circle correct number);
  - ☐ Do not know, but would like the Radiation Unit to find out for me.

Part 8

- This Part concerns PREVIOUS PAYMENTS OF MONEY in connection with lung cancer or the nonmalignant respiratory disease for which this claim is submitted under the Radiation Exposure Compensation Act.
- Answer the question below by placing a check in the box next to the correct answer to each question.

Yes	No	
☐	☐	Have you or anyone else received any payment of money pursuant to final award or settlement on a claim (other than worker's compensation or life and health insurance) against any person (including a corporation) that is based on the illness for which this claim is submitted?

If you checked "YES", please use a separate sheet of paper to identify the date, amount, and person or organization from whom EACH AND EVERY payment of money was received, and explain the circumstances surrounding the payment.

Part 9

Have you hired an attorney to represent you for the purpose of filing this claim? Check one:

Yes ☐ No ☐

NOTE: You are not required to hire an attorney to file this claim. If you do wish to be represented by an attorney, you are responsible for making arrangements for that attorney to be paid.

If "YES", please indicate your attorney's name, address, and phone number here:

First name

Middle name

Last name

Firm name

Mailing address

Zip code

Phone number (day) - -

Phone number (evening) - -

Your attorney must send a letter to the Radiation Exposure Compensation Unit verifying that he/she is qualified as provided in the regulations and authorized to represent you in this matter.

I swear (or affirm) under penalty of perjury that the information in this claim is true, correct, and complete to the best of my knowledge and belief.

Signature of the person identified in Part 1 or Legal Guardian — Date

First name of legal guardian (if applicable)

Middle name

Last name

Mailing address

Zip code

Phone number (day)

Phone number (evening)

Civil Penalty for Presenting Fraudulent Claim or Making False Statements or Using False Record
The claimant 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. 3729).

Criminal Penalty for Presenting Fraudulent Claim or Making False Statements
Fine and imprisonment for not more than 5 years. (See 18 U.S.C. 287, 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, D.C. 20044-0146

Privacy Act

The authority for the collection of this information is the Radiation Exposure Compensation Act of 1990, 42 U.S.C.A. § 2210 note (West Supp. 1991). 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 4 of the claim form. Some or all of the information you provide may be released to federal, state, and local government agencies or private organizations 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 the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect 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, D.C. 20044-0146, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

U.S. Department of Justice
Civil Division

Authorization to Release Medical and Other Information

To: Arizona Tumor Registry
Colorado Cancer Registry
Wyoming Tumor Registry
New Mexico Tumor Registry
Nevada Statewide Cancer Registry
Utah Cancer Registry

I hereby authorize the release of any and all medical and other information in your possession, custody, and control to a representative of the Radiation Exposure Compensation Unit (RECU), Department of Justice, relating to the individual whose name appears on line 1 of this form. This authorization specifically includes the release of abstracts or summaries created or stored by one of the state agencies listed above as a result of its review of the medical and hospital records, physician notes, and lab reports about this individual. This data is required to determine eligibility for compensation under the Radiation Exposure Compensation Act, 42 U.S.C.A. § 2210.

1. Name of the individual whose records are to be released.

_____

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.

_____
Month Date Year

3. Name of the individual requesting release of information (if different from the individual listed on line 1).

_____

4. Social Security Number (if different from the individual listed on line 1).

_____

5. Relationship to the individual listed on line 1.

_____

_____ _____
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

U.S. Department of Justice
Civil Division

Authorization to Release Employment, Medical, and Other Information

To: National Institute for Occupational Safety and Health
Saint Mary's Hospital and Medical Center
University of New Mexico Medical School
New Mexico Tumor Registry

The undersigned hereby authorizes release of all employment, medical, and other information concerning the individual whose name appears on line 1 to a representative of the Radiation Exposure Compensation Program, Department of Justice. This authorization specifically authorizes release of all information gathered in the course of health related studies of uranium miners, uranium mill workers, and any individual who was employed in the transport of uranium ore or vanadium-uranium ore, including, but not limited to: identification and birth date information, employment history, and medical condition information. This data is required to determine eligibility for compensation under the Radiation Exposure Compensation Act, 42 U.S.C. § 2210 note (1994), as amended by P.L. 106-245 (July 10, 2000).

1. Name of the individual whose records are to be released.

_____

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.

_____
Month/Date/Year

3. Name of the individual requesting the release of information (if different from the individual listed on line 1).

_____

4. Social Security Number (if different from the individual listed on line 1).

_____

5. Relationship to the individual listed on line 1.

_____

_____ 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, DC 20044-0146

U.S. Department of Justice
Civil Division

Medical Records Attachment

Listed below are the records which the Radiation Exposure Compensation Program will accept as proof that the person who became ill actually contracted **lung cancer, pulmonary fibrosis, fibrosis of the lung, cor pulmonale related to fibrosis of the lung, silicosis, or pneumoconiosis**.

Tear off this attachment and take it to the doctor or hospital holding the records of the person who became ill with **lung cancer, pulmonary fibrosis, fibrosis of the lung, cor pulmonale related to fibrosis of the lung, silicosis, or pneumoconiosis.**

Show this list to the doctor or hospital and ask them to give you **original or certified copies** of the required medical documentation listed below. Submit the record(s) containing a diagnosis of the disease, if possible. Otherwise, send the records listed below that are available. Call the Radiation Program if you have any questions at 1-800-729-7327.

(A) Lung Cancer

1. If the person with lung cancer is **deceased**, any one of the following records may be submitted as proof of the disease:

a. Pathology report of tissue biopsy, including, but not limited to specimens obtained by any of the following methods:
   - i. surgical resection
   - ii. endoscopic endobronchial or transbronchial biopsy
   - iii. bronchial brushings and washings
   - iv. pleural fluid cytology
   - v. fine needle aspirate
   - vi. pleural biopsy
   - vii. sputum cytology

b. Autopsy report

c. Bronchoscopy report

d. One of the following summary medical reports:
   - i. physician summary report
   - ii. hospital discharge summary report
   - iii. operative report
   - iv. radiation therapy summary report
   - v. oncology summary or consultation report

e. Reports of the radiographic studies, including:
   - i. x-rays of the chest
   - ii. chest tomograms
   - iii. computer-assisted tomography (CT)
   - iv. magnetic resonance imaging (MRI)

f. Death certificate, provided that it is signed by a physician at the time of death.

2. If the person with lung cancer is **alive**, the following medical records must be submitted:

a. Arterial blood-gas studies: a blood-gas study administered at rest in a sitting position, or an exercise blood-gas test; **or**

b. Written diagnosis by a physician that is accompanied by written documentation;

and one of the following:

c. Chest x-rays: A chest x-ray administered in accordance with standard techniques and interpretive reports of a maximum of two National Institute of Occupational Safety and Health certified "B" readers classifying the existence of disease of category 1/0 or higher according to a 1980 report of the International Labor Office (known as the "ILO"), or subsequent revisions;

d. High resolution computed tomography scans (commonly known as "HRCT scans") (including computer assisted tomography scans (commonly known as "CAT scans"), magnetic resonance imaging scans (commonly known as MRI scans), and positron emission tomography scans (commonly known as "PET scans")) and interpretive reports of such scans;

e. Pathology reports of tissue biopsies; or

f. Pulmonary function tests indicating restrictive lung function, as defined by the American Thoracic Society;

(B) Pulmonary Fibrosis or Fibrosis of the Lung

1. If the person with pulmonary fibrosis or fibrosis of the lung is **deceased**, one or more of the following medical records must be submitted:

a. Pathology report of tissue biopsy

b. Autopsy report

c. If x-rays exist, the x-rays **and** interpretive reports of the x-ray(s) by two certified "B" readers classifying the existence of fibrosis of Category 1/0 or greater according to the ILO-1980, or subsequent revisions.

d. If no x-rays exist, an x-ray report

e. Physician summary report

f. Hospital discharge summary report

g. Hospital admitting report

h. Death certificate, provided that it is signed by a physician at the time of death.

2. If the person with pulmonary fibrosis or fibrosis of the lung is **alive**, the following medical records must be submitted:

a. Arterial blood-gas studies: a blood-gas study administered at rest in a sitting position, or an exercise blood-gas test; **or**

b. Written diagnosis by a physician that is accompanied by written documentation;

and one of the following:

c. Chest x-rays: A chest x-ray administered in accordance with standard techniques and interpretive reports of a maximum of two National Institute of Occupational Safety and Health certified "B" readers classifying the existence of the nonmalignant respiratory disease of category 1/0 or higher according to a 1980 report of the International Labor Office (known as the "ILO"), or subsequent revisions;

d. High resolution computed tomography scans (commonly known as "HRCT scans") (including computer assisted tomography scans (commonly known as "CAT scans"), magnetic resonance imaging scans (commonly known as MRI scans), and positron emission tomography scans (commonly known as "PET scans")) and interpretive reports of such scans;

e. Pathology reports of tissue biopsies; or

f. Pulmonary function tests indicating restrictive lung function, as defined by the American Thoracic Society;

(C) Cor Pulmonale Related to Fibrosis of the Lung

1. If the person with cor pulmonale related to fibrosis of the lung is **deceased**, please provide the same documentation as required for proof of pulmonary fibrosis or fibrosis of the lung in section (B)(1) above **and** one or more of the following medical records:

a. Right heart catheterization;
b. Cardiology summary or consultation report;
c. Electrocardiogram;
d. Echocardiogram;
e. Physician summary report;
f. Hospital discharge report;
g. Autopsy Report;
h. Report of physical examination;
i. Death certificate, provided that it is signed by a physician at the time of death.

2. If the person with cor pulmonale related to fibrosis of the lung is **alive**, please provide the same documentation as required for proof of pulmonary fibrosis or fibrosis of the lung in section (B)(2) above.

(D) Silicosis or Pneumoconiosis

1. If the person with silicosis or pneumoconiosis is **deceased**, please provide the same documentation as is required for proof of pulmonary fibrosis or fibrosis of the lung in section (B)(1) above.

2. If the person with silicosis or pneumoconiosis is **alive**, please provide the same documentation as is required for proof of pulmonary fibrosis or fibrosis of the lung in section (B)(2) above.