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APPENDIX B TO PART 130—CONFIDENTIAL PHYSICIAN OR NURSE PRACTITIONER AFFIDAVIT

OMB No. 0915-0244
Expiration date: 02-14-2001

RICKY RAY HEMOPHILIA RELIEF FUND
CONFIDENTIAL PHYSICIAN OR NURSE PRACTITIONER AFFIDAVIT

The U.S. Congress enacted the Ricky Ray Hemophilia Relief Fund Act in 1998 to make compassionate payments of $100,000 to certain individuals with blood-clotting disorders, such as hemophilia, who were treated with antihemophilic factor between July 1, 1982, and December 31, 1987, and who contracted HIV(referred to in Section A below). Certain spouses, former spouses and children (referred to in Section B below) who contracted HIV from these individuals may also be eligible for compassionate payments. Specified survivors of these individuals may also receive payments.

This affidavit regarding medical documentation is to be completed and signed by a physician or nurse practitioner in lieu of medical records or test results. Although you may be asked to provide additional information, complete only those portions of this affidavit that you can answer based on your personal knowledge or a review of medical records.

PRIVACY ACT STATEMENT

Section 103 of Public Law 105-369 and the Debt Collection Improvement Act of 1996 authorize collection of this information. It will be used to determine your eligibility to receive payments. This information will be disclosed to the Department of Health and Human Services and its consultants; and Federal, State or local law enforcement agencies if the Government becomes aware of a possible violation of civil or criminal law. Furnishing the information on this form, including the Social Security Number, is voluntary, but failure to do so may delay or prevent the receipt of a payment. The information collected will be maintained confidentially pursuant to the Privacy Act.

CHECK APPLICABLE BOXES AND PROVIDE INFORMATION AS REQUESTED.

I am a physician or a nurse practitioner. I have been requested by an individual to complete this affidavit and to provide information that I understand will be kept strictly confidential and be used solely to determine eligibility for a compassionate payment under the Ricky Ray Hemophilia Relief Fund Program.

SECTION A. INFORMATION ON INDIVIDUAL WITH BLOOD CLOTTING DISORDER AND HIV

He or she is a person with blood-clotting disorder who has/had HIV and was treated with antihemophilic factor at any time between July 1, 1982, and December 31, 1987.

Name of Individual: _____

Note: the information requested in the following three statements is required for all individuals described in Section A.

[ ] He/she has/had the following blood-clotting disorder:

[ ] He/she received an antihemophilic factor between July 1, 1982, and December 31, 1987.

[ ] He/she was diagnosed as having HIV.

SECTION B. INFORMATION ON ELIGIBLE INDIVIDUAL WITH HIV IF DIFFERENT FROM SECTION A

This section pertains to other individuals who may be eligible for payment under the Program because of their familial relationship to the person described in Section A.

Name of Individual: _____

[ ] He/she was diagnosed as having HIV. **(Note: this information is required for all individuals in Section B).**

(Section B continued, next page)

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[ ] There is reasonable certainty that this individual contracted HIV from the individual identified in Section A. "Reasonable certainty" is defined as having no knowledge based on medical records or other documents that the individual contracted HIV from a source other than the individual identified in Section A. **(Note: This information is required only for an individual filing a petition as the former spouse of the individual described in Section A).**

[ ] This individual acquired HIV through perinatal transmission (transmission of HIV infection from mother to child that occurs during pregnancy, delivery, or breast feeding) from _____ _____. **(Note: This information is required only for an individual filing a petition because he/she acquired HIV through perinatal transmission from the individual in Section A or that individual's current or former spouse).**

SECTION C. SIGNATURE AND SWORN STATEMENT OF PHYSICIAN OR NURSE PRACTITIONER

I swear or affirm under penalty of perjury that the answers I have given to the medical questions listed above in this affidavit are true and correct to the best of my knowledge, information, and belief. (18 U.S.C. § 1621)

Signature: _____ Date: _____

Name (typed or printed legibly): _____

License Number and State Where Licensed: _____

Full Address (number and street): _____

City, State, and Zip Code: _____

Phone: _____

Refer to the definitions for several medical terms in the Rule, 42 CFR Part 130: antihemophilic factor §130.2(b), blood-clotting disorder §130.2(c), hemophilia §130.2(h), HIV infection or HIV §130.2(i), perinatal transmission §130.2(m).

PUBLIC BURDEN STATEMENT

An agency may not conduct or sponsor, and any person is not required to respond to, a collection of information unless it displays a currently valid OMB Control Number. The OMB Control Number for this project is 0915-0244. Public reporting burden for this collection of information is estimated to average 1 hour 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.

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