

AGENT ORANGE QUESTIONNAIRE

Identification of Class Member							
Name:							
Address:	<table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;">Apt/No/Street:</td> <td style="width: 40%; border: none;">City:</td> </tr> <tr> <td style="border: none;">Province:</td> <td style="border: none;">Postal Code:</td> </tr> </table>	Apt/No/Street:	City:	Province:	Postal Code:		
Apt/No/Street:	City:						
Province:	Postal Code:						
Home Phone:	Work Phone:						
Date of Birth:	E-mail:						
<p>Please indicate your previous address(es) where you were living when you believe that you or your property may have been exposed to the Chemicals sprayed at Gagetown:</p>							
Address:	<table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;">Apt/No/Street</td> <td style="width: 40%; border: none;">City:</td> </tr> <tr> <td style="border: none;">Province:</td> <td style="border: none;">Postal Code:</td> </tr> <tr> <td colspan="2" style="border: none;">Date when resided at this address:</td> </tr> </table>	Apt/No/Street	City:	Province:	Postal Code:	Date when resided at this address:	
Apt/No/Street	City:						
Province:	Postal Code:						
Date when resided at this address:							
Address:	<table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;">Apt/No/Street</td> <td style="width: 40%; border: none;">City:</td> </tr> <tr> <td style="border: none;">Province:</td> <td style="border: none;">Postal Code:</td> </tr> <tr> <td colspan="2" style="border: none;">Date when resided at this address:</td> </tr> </table>	Apt/No/Street	City:	Province:	Postal Code:	Date when resided at this address:	
Apt/No/Street	City:						
Province:	Postal Code:						
Date when resided at this address:							
Particulars of Claim							
Are you claiming for personal injuries you sustained as a result of exposure to Chemicals at Gagetown?							
Are you claiming because a family member sustained personal injury as a result of exposure to Chemicals at Gagetown?							
Are you claiming for property damage you sustained as a result of exposure to Chemicals at Gagetown?							
Are you claiming because a family member sustained property damage as a result of exposure to Chemicals at Gagetown?							
Were you a member of the military during your time in/around Gagetown?							
Was your family member a member of the military during their time in/around Gagetown?							

SECTION 1: PERSONAL INJURY

If applicable, please describe how you believe you were exposed to the Chemicals sprayed at CFB Gagetown, as well as the dates of exposure :

Dates: _____

If applicable, please describe the injuries you sustained as a result of exposure to the Chemicals sprayed at CFB Gagetown. Symptoms possibly related to Chemical exposure include: skin disorders, nervous or neurological disorders, diabetes, numerous forms of cancers, heart disease, birth defects, miscarriages, respiratory problems, and liver problems.

- | | | |
|--|------------------------------|-----------------------------|
| Is there a family history for heart disease? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is there a family history for nervous or neurological disorders? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is there a family history for diabetes? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you a smoker? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you overweight? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you a heavy drinker? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If applicable, please describe the treatment you have received for the injuries resulting from the exposure to Chemicals sprayed at CFB Gagetown, including where treatment was sought, and how long treatment was given:

Where treatment was sought: _____

Duration of treatment: _____

Current Family Physician:

Name:			
Current Address:	Apt/No/Street:	City:	
	Province:	Postal Code:	

Other Physicians:

Name:		Type of Physician:	
Current Address:	Apt/No/Street:	City:	
	Province:	Postal Code:	
Reason for consult:			

Name:		Type of Physician:	
Current Address:	Apt/No/Street:	City:	
	Province:	Postal Code:	
Reason for consult:			

SECTION 2: PROPERTY DAMAGE

If applicable, please describe how you believe your property was exposed to the Chemicals sprayed at CFB Gagetown, as well as the dates of exposure:

Dates:

If applicable, please describe the property damage you sustained as a result of exposure to the Chemicals sprayed at CFB Gagetown:

Additional Comments?:
