DMM

C-8 (PFOA) Medical Monitoring Program
c/o GCG
PO Box 10030
Dublin, Ohio 43017-6630
www.C-8MedicalMonitoringProgram.com

Registrant ID:

Control Number:

C-8 (PFOA) MEDICAL MONITORING PROGRAM

CLASS MEMBER REGISTRATION & ELIGIBILITY FORM

I. CLASS MEMBER INFORMATION

Name (first, middle initial, last):

Address:

City: **State:** **Zip:**

Telephone (Day): **Telephone (Evening):** **Telephone (Cell):**

Date of Birth: **Social Security Number:**

Email Address:

Driver's License No. / State ID (optional): **State of Issuance:** **Gender:** **Male** ☐ **Female** ☐

Important - *This form should be completed IN CAPITAL LETTERS using BLACK or DARK BLUE ballpoint/fountain pen. Characters and marks used should be similar in the style to the following:*

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 1 2 3 4 5 6 7 0

II. AUTHORIZED REPRESENTATIVE

Complete this section only if you are an Authorized Representative of a Class Member who is (1) a minor, or (2) lacking capacity or incompetent. Each Registrant is required to complete their own Registration and Eligibility Form. A person acting as an Authorized Representative for multiple minor children or individuals will need to complete this Form for each individual Registrant.

A. Check all that apply for the Class Member for whom you are an Authorized Representative.

☐ **Minor**

☐ **Person Lacking Capacity or Incompetent Person**

B. Provide the following information about yourself (the Authorized Representative filling out this form):

Name (first, middle initial, last):

Address:

City: **State:** **Zip:**

Telephone (Day): **Telephone (Evening):** **Telephone (Cell):**

C. Identify the authority giving you, the Authorized Representative, the right to act on behalf of the person identified in Section I above. You must also provide copies of documentation verifying your authority to act, such as a power of attorney, birth certificate or a court order stating your authority to act, or, if no such documents are available, documents establishing your legal relationship to the person identified in Section I of the Registration Form.

III. BASIS FOR PARTICIPATION IN MEDICAL MONITORING PROGRAM

Which of the following is the basis for your participation in this Medical Monitoring Program? Check every box that you think applies.

I consumed water from one of the following sources for at least one year before December 4, 2004:

☐ Lubeck Public Service District

☐ Little Hocking Water Association

☐ City of Belpre

☐ Village of Pomeroy

☐ Mason County Public Service District (WV)

☐ Tuppers Plains-Chester water District

☐ Certain private water sources containing 0.05 ppb or > of C-8 specified on Exhibit 1 to the Notice included in the packet.

IV. PROOF OF ELIGIBILITY

Unless you check below that you participated in the C-8 Health Project, you must provide documentary proof of your use of one of the water sources identified above in Section III for at least one year before December 4, 2004.

Please check which forms of documentary evidence you are submitting to establish proof of residency and eligibility to participate in the Program. (Please provide two of the following examples of proof of residency or employment.)*

- ☐ Copy of Lease or Title to Property
- ☐ Driver's License or Governmental-Issued ID
- ☐ 1099 form(s)
- ☐ Tax return(s)
- ☐ Utility Bills or Phone Bills
- ☐ School records (to show enrollment for at least one year before December 4, 2004)
- ☐ **Other (Describe):
- ☐ **Other (Describe):

**See below for a list of other documentary evidence you may submit.

☐ **Check here if you participated in the C-8 Health Project.**

***Note:** C-8 Health Project participants are not required to submit additional documentation at this time, however you may submit additional supporting documentations if you choose to do so. The Administrator will review your previously submitted eligibility documentation and any additional documentation submitted, and will contact you directly if additional information is required.

Additional Forms of Documentary Proof

- **Bank Statements**
- **Birth Certificate / Marriage Certificate or License**
- **Employment Records (e.g. Paystub, W-2, W-4)**
- **Homeowner's / Renter's insurance card**
- **Letter from Water District**
- **Real Property Tax Receipt**
- **Rental / Property Ownership Document**
- **Tax Documents (e. g. Letter from IRS, Personal Property Tax Receipt)**
- **Voter Registration Card**
- **Court Document**
- **Vehicle Document (Insurance, Registration or Title)**
- **Cancelled check showing name and address**
- **Major Credit Card Statement (as many as needed to show occupancy for a one year period)**

V. SIGNATURE

By signing this Form, I understand and agree that all information submitted by me and my physicians to this Medical Monitoring Program will be held in strict confidence and will be used solely for the purpose of administration of the Medical Monitoring Program. The Medical Panel may use the information to recommend when to do future screening tests and may publish information and results of the Medical Monitoring Program in medical journals or other reports. Any information about these findings will not identify me in any way and will be used only to analyze the Program as a whole.

Name of Class Member Registrant:

Signature: ***(Required to complete Registration)*** **Date:** / /

Name of Authorized Representative:
(If completing this form for a Minor Or Person Lacking Capacity/Incompetent Adult, only the Authorized Representative's signature is required)

Signature of Authorized Representative: **Date:** / /

Relationship to Class Member Registrant:

Return completed Form to Administrator at the following address:

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