Canadian Thalidomide Survivors Support Program
Step 1 – Preliminary Screening Application

Any ***living*** individual who believes that they are a thalidomide survivor, including those previously denied under the Government of Canada's 1991 Extraordinary Assistance Plan for Thalidomide Victims or the 2015 Thalidomide Survivors Support Program, must submit a **Preliminary Screening Application** for assessment to the Administrator prior to the application **deadline of June 3, 2024** ***and*** must proceed successfully through all the three steps below to be eligible for support under the "Canadian Thalidomide Survivors Support Program ("CTSSP").

Step 1: Preliminary Screening

Step 2: Probability Assessment

Step 3: Multi-Disciplinary Committee Review

For additional information about each Step, please visit www.tsspcanada.ca.

STEP 1: Instructions

1. Complete the attached Preliminary Screening Application in full. Incomplete applications will result in processing delays.
2. Provide the requested documentation and photographs as requested in the application.
3. Provide a photocopy of the required government issued identification.
4. Return the completed Preliminary Screening Application, required documentation, photographs, and identification postmarked by June 3, 2024 to the Administrator at:

Canadian Thalidomide Survivors Support Program
PO Box 507 STN B, Ottawa ON, K1P 5P6
info@tsspcanada.ca; Fax: 1-866-262-0816

Upon receipt, the Administrator will review your completed Preliminary Screening Application and make a determination regarding your eligibility to move to Step 2, the Probability Assessment.

You will be notified in **writing** once a decision has been made.

Canadian Thalidomide Survivors Support Program
Step 1 – Preliminary Screening Application

Privacy Statement:
The information requested in this Canadian Thalidomide Survivors Support Program Preliminary Screening Application is being collected, used and retained by the Canadian Thalidomide Survivors Support Program Administrator ("Administrator") and its Agents for the purpose of operating and administering the Canadian Thalidomide Survivors Support Program Administration pursuant to the *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c. 5 ("PIPEDA"). The information may be provided to the Government of Canada in order to facilitate the administration of the Canadian Thalidomide Survivors Support Program. Personal information is protected under federal legislation, including PIPEDA and the *Privacy Act*, and personal information may be used or disclosed in accordance with applicable legislation. You have the right to request access to your personal information. To do so, call 1-877-507-7706 or 1-877-627-7027 (TTY).

Section 1: Thalidomide Claimant Contact Information

Language Preference:	☐ English	☐ French
Communication Preference:	☐ Mail	☐ Email *
First Name:		
Middle Name(s):		
Last Name:		
Mailing Address:		
City/Town:		
Province/Territory/State/Country:		
Postal Code/Zip Code:		
Primary Telephone Number:	( ) –	
Alternate Telephone Number:	( ) –	
Email Address:		

*If your communication preference is email, please add info@tsspcanada.ca to your email address book.

Section 2: Legally Appointed Representative Information

(Leave this section blank if the Claimant does not have a Legally Appointed Personal Representative)

This section is to be completed **only** if you have been **legally** appointed to administer the Claimant's affairs. You MUST provide proof of your authority to act as the Personal Representative of the Claimant. Please complete all boxes in both Section 1 on the previous page for the Claimant and Section 2 below for yourself.

I have enclosed a **certified true** photocopy of one (1) of:	Please check (✓) the applicable box: ☐ Authority to Act ☐ Court Order ☐ Other: _____
First Name:	
Last Name:	
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	( ) –
Alternate Telephone Number:	( ) –
Email Address:	
Relationship to Claimant:	

Section 3: Person who helped complete this application

☐ **Same as Section 2 (If box is checked, no need to complete Section 3 boxes below)**

First Name:	
Last Name:	
Email Address or Phone Number:	
Relationship to Claimant:	

Section 4: Claimant History

Claimant's Previous or Alternative Name(s):	
Sex at Birth:	☐ Male ☐ Female
Gender Identity:	☐ Man ☐ Woman ☐ Other: _____
Date of Birth (mm/dd/yyyy):	
Place of Birth (City, Province, Country):	
Description of your Thalidomide Related Injuries: • Be specific in your description • Indicate if the injury was present at birth or developed after you were born • Identify any corrective surgeries that you underwent • Use extra pages if needed	***Head (including face, ears and eyes):*** ☐ Not Applicable ☐ Documents Attached ☐ Photographs Attached

Description of your Thalidomide Related Injuries: • Be specific in your description • Indicate if the injury was present at birth or developed after you were born • Identify any corrective surgeries that you underwent • Use extra pages if needed	***Arms (including hands and fingers):*** ☐ Not Applicable ☐ Documents Attached ☐ Photographs Attached
Description of your Thalidomide Related Injuries: • Be specific in your description • Indicate if the injury was present at birth or developed after you were born • Identify any corrective surgeries that you underwent • Use extra pages if needed	***Legs (including hips and feet):*** ☐ Not Applicable ☐ Documents Attached ☐ Photographs Attached

Description of your Thalidomide Related Injuries: • Be specific in your description • Indicate if the injury was present at birth or developed after you were born • Identify any corrective surgeries that you underwent • Use extra pages if needed	***Internal Organs (including nerves):*** ☐ Not Applicable ☐ Documents Attached ☐ Photographs Attached

Please use the space below to share any additional information about your health that you would like the Administrator to know. Please use extra pages if needed.

Section 5: Birth Mother History

Birth Mother's First Name:	
Birth Mother's Last Name:	
Birth Mother's Previous Name(s):	
List all known cities, provinces and countries where your Birth Mother resided before you were born indicating when and where (if known):	

Please tell us about your Birth Mother's ingestion of Thalidomide including information about how/from whom she got the drug, when she ingested it and how many times she ingested the drug if known. If you have documentation such as medical records for you or your Birth Mother that mention thalidomide or affidavits from anyone who has knowledge of the ingestion (e.g. family members, friends or others), you may include photocopies of those with your application. Please use additional pages as needed.

Section 6: Photo Identification and Privacy

Proof of identification is required by **ALL** Claimants. Legally appointed Personal Representatives must provide identification for **both** the Claimant and the Personal Representative.

Please submit a photocopy of one (1) of the following government issued pieces of identification for proof of identity purposes. The identification **must include your date of birth**:

- Birth Certificate
- Baptismal Certificate
- Valid Provincial Driver's License
- Valid Provincial Photo ID Card (must include date of birth)
- Valid Canadian Passport

To protect your privacy and to help confirm your identity when we are speaking with you, please provide a security word, number or combination thereof that you will be asked to provide when you contact us. Please choose something that you will be able to remember.

Security Question (hint in case you forget your security answer):

_____

Security Answer: _____

Section 7: Declaration and Signature

This section must be completed by the Claimant or the legally appointed Personal Representative. Please read the following Declaration carefully before signing.

Declaration: I have completed the Canadian Thalidomide Survivors Support Program Preliminary Screening Application and I understand that the Administrator will be reviewing my Application for completeness and may need to contact me to request additional information. I understand that completing this application does not automatically mean I qualify for the Canadian Thalidomide Survivors Support Program. I must proceed successfully through all the three steps to be eligible for support under the Canadian Thalidomide Survivors Support Program ("CTSSP").

I agree to the sharing of my personal information, including but not limited to my contact information, with the Administrator, the Government of Canada and necessary authorized third parties, only for the purpose of processing my request for assessment.

By signing below, I indicate my agreement to the contents of this Declaration.

Claimant/Legally Appointed Personal Representative:

Print Name: _____

Signature: _____

Date: _____
(mm/dd/yyyy)

All Claimants or legally appointed Personal Representatives must sign or sign with a mark in Section 7 in the presence of a witness who may be a relative. The witness must complete the Witness information below and sign the Witness Declaration on the next page.

Witness' First Name	Witness' Last Name	
City/Town	Province/Territory/State	Country
Relationship to Claimant/Personal Representative		

Witness Declaration: I have witnessed the signature or mark of the Thalidomide Claimant or legally appointed Personal Representative. Where the Thalidomide Claimant or legally appointed Personal Representative signed with a mark, I have read the content of this Canadian Thalidomide Survivors Support Program Preliminary Screening Application to the Thalidomide Claimant and/or his/her Personal Representative, who signed with a mark, who understands and confirms the information.

Print Name: _____

Signature: _____

Date: _____
(mm/dd/yyyy)

Please make sure the following has been included with your Application when returning it to the Administrator:

☐ Supporting documentation and photographs

☐ Proof of identification for Claimant

☐ Proof of identification for legally appointed Personal Representative (if applicable)

☐ Certified true copy of authority to act on behalf of the Claimant (if applicable)

☐ Security question and answer provided in Section 6

☐ Signed and dated Declaration for Claimant/Personal Representative in Section 7

☐ Completed, signed and dated Witness section by Witness in Section 7

Please return the completed Canadian Thalidomide Survivors Support Program Preliminary Screening Application to the Administrator to:

Canadian Thalidomide Survivors Support Program
PO Box 507 STN B, Ottawa ON, K1P 5P6
info@tsspcanada.ca; Fax: 1-866-262-0816

CTSSP APPLICATION DEADLINE
Postmarked by JUNE 3, 2024