WTC VCF AUTHORIZATION

NEW YORK STATE | Workers' Compensation Board

World Trade Center September 11th Victim Compensation Fund (VCF) Authorization

Claimant Name *(use ink only – ballpoint pen, if possible)*	Date of Birth (MM/DD/YYYY)	Social Security Number
	/ /	- -

Mailing Address	City	State	Zip

This authorization form allows the Workers' Compensation Board to obtain any information relating to my claim under the September 11th Victim Compensation Fund of 2001 (Victim Compensation Fund or VCF) from the U.S. Department of Justice for the purpose of evaluating my World Trade Center volunteer claim for compensation. This information may include, but is not limited to, medical, government and financial information about me.

I acknowledge that I have the right to revoke this authorization at any time, except to the extent that the Workers' Compensation Board has already acted based on this authorization. To revoke this authorization, send a letter to the Workers' Compensation Board at the address listed below.

Copies of this authorization that show my signature are as valid as the original release signed by me.

Signature of Claimant	Date (MM/DD/YYYY)
	( ) -

Printed Name

If the claimant is unable to sign, the person signing on his or her behalf must fill out and sign below:

Your Name	Signature	Relationship to patient	Date (MM/DD/YYYY)
			/ /