VESC FORM 1004
Application for Filing a Claim for Compensation for Victims of the 1924 Virginia Eugenical Sterilization Act

Instructions:

1. **Persons eligible to request compensation ("claimant") must have been:**
   - Sterilized under the 1924 Virginia Eugenical Sterilization Act pursuant to the Code of Virginia Chapter 394 ("Act")
   - Living as of February 1, 2015; and
   - Sterilized while a patient at Eastern State Hospital, Western State Hospital, Central State Hospital, Southwestern State Hospital, or the Central Virginia Training Center (formerly known as the State Colony for Epileptics and Feeble-Minded) between 1924 and 1981

2. Persons claiming eligibility for compensation who were sterilized under the 1924 Virginia Eugenical Sterilization Act or their lawfully authorized representative must complete this application form and attach the relevant documentation as specified on this form. No application will be processed until the Department determines that it is complete with all documentation.

3. Applications must be notarized.

4. Applications must be mailed individually to the Department through the United States Postal Service. The Department will not accept applications delivered in any other manner and will not accept more than one application in a single mailing.

5. Mail the application form and all supporting documents to:

    ATTENTION: Virginia Eugenical Sterilization Act Compensation Program
    Virginia Department of Behavioral Health and Developmental Services
    P.O. Box 1797
    Richmond, Virginia  23218-1797
Section I: Claimant Information (please print)

1. Claimant’s Current Name ________________________________________________________________
   First, Middle, Last

2. Name at Time of Sterilization ____________________________________________________________
   First, Middle, Last

3. If Claimant’s name at time of sterilization was different from current name, attach
documentation of name change (e.g., marriage certificate or other documentation).

4. If the Claimant died on or after February 1, 2015, attach a certified copy of a state
   issued death certificate.

5. Claimants Date of Birth _______/_______/_______
   Month   Day   Year

6. Proof of Identity: (Check at least one and attach a copy of the document)
   __ State issued driver’s license
   __ State issued picture identification card
   __ United States passport
   __ Foreign passport with Visa, I-94 or I-94W with picture
   __ United States military card, active or retired member

7. Current Mailing Address______________________________________________________________

   City, State, Zip______________________________________________________________

   Phone (_____) ______________________ Email______________________________

Section II: Documentation of Sterilization Procedure

1. Facility where Claimant was a patient when sterilization was performed (check one)
   __ Eastern State Hospital
   __ Western State Hospital
   __ Central State Hospital
   __ Southwestern Mental Health Institute (Southwestern State Hospital)
   __ Central Virginia Training Center (State Colony for Epileptics and Feeble-Minded)
2. Date and year of sterilization (please print)________________________________________________________

3. Documentation that the sterilization was performed under the authority of the 1924 Virginia Eugenical Sterilization Act (check at least one of the following and attach a copy of the documentation).
   __ Letter notifying a parent, guardian or lawfully authorized representative of the claimant that the sterilization procedure was performed.
   __ Progress notes from the claimant's hospital record documenting that the sterilization procedure was performed.
   __ Case summary from the claimant's hospital record documenting that the sterilization procedure was performed.
   __ Physician's order for sterilization from the claimant's hospital record.
   __ Operative record of sterilization from the claimant's hospital record.
   __ Sterilization record summary from the claimant's hospital record.
   __ Nurses notes documenting post-operative care provided to the individual claimant, following the sterilization.
   __ Other documents that show proof of sterilization having been performed under the authority of the 1924 Virginia Eugenical Sterilization Act.

Section III: Legally Authorized Representative Information (if applicable)

1. If the person completing the application is doing so on behalf of the Claimant, check one of the following and attach a copy of documentation to prove the legal authority to act on behalf of the Claimant.
   __ I am permitted by law or regulation to act on behalf of the Claimant; or
   __ I am a personal representative of the estate of the Claimant, as defined in Virginia Code § 64.2-100, of a Claimant who died on or after February 1, 2015.

2. Identifying information of the legally authorized representative of the Claimant (Print)

   First, Middle, Last Name:  ____________________________________________________________________
   Mailing Address________________________________________________________________________________
   City, State, Zip__________________________________________________________________________________
Section IV: Certification

I hereby certify the authenticity of the documents referenced in and submitted as evidence for compensation to victims of sterilization. I also hereby acknowledge that I have read the instructions and understand that this application will not be accepted for evaluation or for the award of compensation if it is determined that it has not been prepared in compliance with the instructions.

_________________________________________ Date __________
Signature of Claimant or Claimant’s Legally Authorized Representative

Section V: Acknowledgment of Individual

County/City of _________________________________ Commonwealth Of Virginia.

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____.

by ____________________________________ Name of person seeking acknowledgement

Notary Public's Signature: ________________________________________________

Notary's Registration Number: _____________________________________________

My Commission Expires: _________________________________________________

Notary Seal