PARAMED CLASS ACTION SETTLEMENT: CLAIM FORM
Private & Confidential

Please read this Claim Form carefully and complete it in full. Failure to fully complete this Claim Form and/or sign it will result in your Claim being rejected. Once completed and signed, submit this Claim Form to the Claims Administrator on or before January 30, 2024.

This Claim Form is for Settlement Class Members who wish to claim compensation under the Settlement Agreement. "**Settlement Class Members**" means all persons who (1) received wound care involving the use of medical instruments at ParaMed Inc.'s clinics located at 124 Barker Street, 1340 Huron Street, and 148 Fullarton Street, Suite 200 in London, Ontario between January 1, 2008 and July 27, 2018, (2) were contacted by ParaMed Inc. and advised that they may have been exposed to infection and should be tested for hepatitis B, hepatitis C, and human immunodeficiency virus (HIV), **and** (3) tested positive for hepatitis B, hepatitis C, or HIV, or where such person is deceased, the personal representative of the estate of the deceased person.

CATEGORY/CATEGORIES OF CLAIM:
Check one or more of the boxes below to indicate the type(s) of infection with which you were diagnosed subsequent to receiving wound care at ParaMed Inc.'s clinics and that you claim resulted from ParaMed Inc's alleged failure to follow public health standards in the sterilization of medical instruments used at its clinics. Only the three types of infections below are eligible for compensation under the Settlement Agreement. Please note that you **must** submit supporting documentation for each category claimed (i.e., each type of infection claimed) (see Section 7 below).

☐ Human Immunodeficiency Virus (HIV)

☐ Hepatitis B

☐ Hepatitis C

1. Claimant Identification

Provide the following information about the person submitting this Claim, or, if applicable, on whose behalf you are submitting this Claim, **and provide proof of identity**:

First Name:		Middle Initial:
Last Name:		
Prior Names:		
Street Address:		Suite Number:
City:	Province/Territory:	Postal Code:
Phone Number:	Email Address:	
Date of Birth (dd/mm/yyyy):		

Documentation: Enclose a copy of a valid, government-issued photo ID that matches the name and contact information entered above.

2. Representative Identification (if you are submitting this Claim on behalf of a Settlement Class Member who is deceased or a minor or for another reason)

If you are submitting this Claim as a representative on behalf of a Settlement Class Member, provide the following personal identification information **and attach a copy of the Certificate of Appointment of Estate Trustee, Power of Attorney or other document establishing your authority to act on this person's behalf**:

YOU ARE SUBMITTING THIS CLAIM ON BEHALF OF SOMEONE WHO IS:

☐ DECEASED ☐ A MINOR ☐ OTHER REASON (Identify):

Representative's Full Name:		
Representative's Relationship to Claimant:		
Representative's Street Address:		Suite Number:
City:	Province/Territory:	Postal Code:
Representative's Phone Number:	Representative's Email Address:	
Representative's Law Firm Name (if applicable):		

3. Legal Counsel Identification (if applicable)

This section is to be completed only if a lawyer is representing the Claimant. Please note that if you complete Section 3 below, all correspondence will be sent to your lawyer, who must notify the Claims Administrator of any change in mailing address. If you change lawyers, you must notify the Claims Administrator in writing of the new information.

Law Firm Name:		
Lawyer's Full Name:		
Street Address:		Suite Number:
City:	Province/Territory:	Postal Code:
Phone Number:	Email Address:	
Law Society Number:		

4. Information Regarding the Claimant's Wound-Care History at ParaMed Inc.'s Clinics

(a) By checking one or more of the boxes below, indicate the ParaMed Inc. wound-care clinic(s) you attended for wound care involving the use of medical instruments between January 1, 2008 and July 27, 2018:

☐ 124 Barker Street

☐ 1340 Huron Street

☐ 148 Fullarton Street, Suite 200

(b) To the best of your recollection, in the space below, provide the dates, between January 1, 2008 and July 27, 2018, on which you received wound care at the above ParaMed Inc. wound care clinic(s):

5. Information Regarding the Medical Professional(s) Who Diagnosed and/or Treated Your Hepatitis C, Hepatitis B, and/or HIV Infection(s)

In the space below, list each medical professional who diagnosed and/or treated the Hepatitis C, Hepatitis B, and/or HIV infection(s) with which you were diagnosed subsequent to receiving wound care at ParaMed Inc.'s clinics and that you claim resulted from ParaMed Inc's alleged failure to follow public health standards in the sterilization of medical instruments used at its clinics. **Please provide name(s), address(es) and phone number(s) for each medical professional.**

6. Information Regarding Your Diagnosis with Hepatitis C, Hepatitis B, and/or HIV

In the space below, indicate the date(s) on which you were diagnosed with Hepatitis C, Hepatitis B, and/or HIV. If you were diagnosed with more than one type of infection, specify which date applies to which diagnosis.

7. Supporting Documentation

Note: Failure to provide supporting documentation will result in your Claim being rejected.

Attach to this Claim Form documentation from the medical professional(s) who diagnosed you with Hepatitis C, Hepatitis B, and/or HIV demonstrating the following: (i) that you are/were infected with Hepatitis C, Hepatitis B, and/or HIV; and (ii) the date of your diagnosis. Please note that you **must** submit supporting documentation for each category claimed (i.e., each type of infection claimed).

8. Privacy Statement

All personal information provided by or on behalf of the Claimant to the Claims Administrator will be handled in accordance with applicable privacy laws. Such information will be used solely for the purposes of administering the Settlement Agreement. The information provided will be treated as private and confidential and will not be disclosed without the express written consent of the Claimant, except in accordance with the Settlement Agreement, Approval Order and/or other orders of the Ontario Superior Court of Justice.

9. Signature & Date

By signing below, I declare under penalty of perjury that I am a Settlement Class Member or a representative of a Settlement Class Member as disclosed in Section 2 above, and that the information provided and submitted in this Claim Form is true and correct to the best of my knowledge. I understand that this Claim Form and the supporting documentation attached hereto may be subject to audit, verification, and review by the Claims Administrator and/or Court. I also understand that if the information in this Claim Form or the supporting documentation attached hereto is believed or found to be fraudulent, I will not receive any payment. I agree to participate in the Settlement.

_____ _____

Date Signature of Claimant (or Representative)

_____

Printed Name of Claimant (or Representative)

_____ _____

Date Signature of Claimant's Lawyer (if any)

_____

Printed Name of Claimant's Lawyer

10. Reminder Checklist

☐ I have reviewed this Claim Form for completeness and correctness.

☐ I have signed and dated this Claim Form.

☐ I have attached the required supporting documentation for each category claimed (i.e., each type of infection claimed)**.**

☐ I have made a copy and kept a copy of this Claim Form and all supporting documentation for my records.

11. Submit this Claim Form (with required supporting documentation attached)

Once completed and signed, submit this Claim Form, with the required supporting documentation attached, to the Claims Administrator by mail or email at the contact information below **on or before January 30, 2024.**

If you fail to submit this Claim Form and/or supporting evidence and documentation on or before January 30, 2024, you will not be eligible for any compensation whatsoever (i.e., you will not get paid). Sending in a Claim Form late will be the same as doing nothing.

Attn: ParaMed Class Action Settlement Claims Administrator
McKenzie Lake Lawyers LLP
140 Fullarton Street, Suite 1800
London, ON N6A 5P2
Email: christina.noble@mckenzielake.com

Please note that if your Claim is successful, the Claims Administrator will mail the individual compensation cheques within sixty (60) days of the completion of the Successful Claims Report. This process will take some time, and your patience is appreciated. When the cheques have been mailed, an announcement will be posted on Class Counsel's website (https://www.mckenzielake.com/paramed-class-action). Please check this website periodically for updates on the status of the Settlement.

If you have any questions about this Claim Form or the Settlement generally, please visit Class Counsel online at (https://www.mckenzielake.com/paramed-class-action), email christina.noble@mckenzielake.com, or call 1-844-672-5666.