

SENECA LAKE SPRAY PARK - CLASS ACTION CLAIMANT FORM

**Complete a Separate Form for Each Person Affected by the Outbreak of Cryptosporidiosis
At the Seneca Lake Spray Park in 2005**

(Additional forms, if needed, are available at the website *www. SprayParkOutbreak.com.*)

Please Print Clearly and Sign at the Bottom of Page 2

Q: Who is an "Ill Person"?

A: Someone who suffered an infection with the intestinal parasite **cryptosporidia** as a result of (1) visiting the Seneca Lake Spray Park between June 1 and August 17, 2005 or (2) being exposed to someone who was infected with cryptosporidia after visiting the Seneca Lake Spray Park between June 1 and August 17, 2005.

Full Name of Ill Person: _____

Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____

Mobile Telephone: _____ Email: _____

Name of Person Completing Form
(If Different from Ill Person): _____

Relationship to Ill Person: ___ Self ___ Spouse ___ Parent ___ Other: _____

Ill person was sick because (Check only one):

___ He/she had gone to Seneca Lake Spray Park between June 1 and August 17, 2005.

___ He/she had contact with someone else who was ill caused by visiting Seneca Lake Spray Park between June 1 and August 17, 2005.

___ The illness was caused by something else. Specify: _____

Ill person's symptoms:

___ Diarrhea ___ Nausea ___ Fever ___ Vomiting ___ Stomach Cramps

___ Other (Please Describe): _____

Did the symptoms begin within two weeks of visit to Seneca Lake Spray Park? ___ Yes ___ No

How long did they last? ___ 1 day ___ 2 - 3 days ___ 4 - 6 days ___ 7+ days

Did you have laboratory tests confirm a positive result for cryptosporidium? ___ Yes ___ No

Name of laboratory where test was conducted: _____

Address of laboratory: _____

Did ill person see a doctor or other health care provider for illness associated with Seneca Lake Spray Park?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, dates of visits: _____	
	Where (name and location of hospital, doctor, clinic, etc.) _____	
Did a health care provider diagnose ill person as having cryptosporidiosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did a health care provider inform the ill person that a pre-existing health condition was made worse from his/her visit to Seneca Lake Spray Park?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please explain: _____		
Was payment made to receive medical care or treatment in connection with cryptosporidiosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If payment was made, who paid? _____	How much? \$	_____

Did ill person miss hours or days at work as a result of illness associated with Spray Park?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many? _____ Hours OR _____ Days
If missed work, how much salary/pay did ill person lose?		\$ _____
Ill Person's Occupation or Job Title: _____		
Name of Employer: _____		
Address of Employer: _____		

The undersigned hereby affirms under penalty of perjury under the laws of the State of New York that the information provided above is true and correct to the best of my knowledge and belief.

Signature

Date

Please return by September 30, 2008 to:

Seneca Lake Claims Administrator
c/o The Notice Company
P.O. Box 455
Hingham, MA 02043