STATE OF CALIFORNIA

Forced or Involuntary Sterilization Compensation Program

Legally Authorized Representative Designation Letter

VCB–31–10004 (Rev. 01/2022)

***Required**

*Date: _____
MM / DD / YYYY

I, _____ , hereby designate _____
**Claimant name* **Legally Authorized Representative name*

to be my Legally Authorized Representative for the Forced or Involuntary Sterilization Compensation Program through the California Victim Compensation Board. This allows the representative to apply for compensation on my behalf, receive communications and provide any necessary documents or information to determine program eligibility.

Legally Authorized Representative Information

*Full Legal Name: _____ *Relationship to the Claimant: _____
First, Middle, Last

Agency Name *(if applicable)*: _____ Type of Agency *(if applicable)*: _____

*Phone: _____ Extension: _____ Email: _____

*Mailing Address: _____
Street Number and Name or P.O. Box

_____
Address 2 (Apartment or Unit #)

_____
City, State, ZIP

I understand that all future program communications will be sent to my designated authorized representative.

Claimant

*Printed Name: _____
First, Middle, Last

*Signature: _____ *Date: _____
MM/DD/YYYY

Authorized Legal Representative

*Printed Name: _____
First, Middle, Last

*Signature: _____ *Date: _____
MM/DD/YYYY

Mail, email or fax completed form to:

California Victim Compensation Board
c/o Forced or Involuntary Sterilization Compensation Program
P.O. Box 591, Sacramento, CA 95812-0591
Email: FISCP@victims.ca.gov | Fax: 916-491-6429

For more information:

1-800-777-9229 | Hearing impaired, call the California Relay Service (711)
Our Customer Service Unit is available Monday through Friday between the hours of 8 a.m. and 5 p.m.