STATE OF CALIFORNIA

Forced or Involuntary Sterilization Compensation Program

Contact Information Change Form VCB–31–10008 (Rev. 01/2022)

Required

Application Number: ____________________

*Claimant Name *(as submitted on the application)*: ______________________________
First, Middle, Last

Claimant Information *(complete only updated information)*

*Full Legal Name: ______________________________
First, Middle, Last

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

____
Address 2 (Apartment or Unit #)

____
City, State, ZIP

Phone: ____________________ Email: ____________________

Is the claimant currently in the custody of the Department of Corrections and Rehabilitation (CDCR)?

No. Yes. If yes, provide the Claimant's full name *(if different than above)* along with CDCR identification number, housing unit and cell number.

Full Name: ______________________________
First, Middle, Last

CDCR Number: ______________________________

Housing Unit: ____________________ Cell Number: ____________________

Legally Authorized Representative of the Claimant *(if applicable)*

To update the Legally Authorized Representative's contact information, please complete the updated information below.

Full Name: ______________________________
First, Middle, Last

Agency Name *(if applicable)*: ______________________________

Type of Agency *(if applicable)*: ____________________ Relationship to the Claimant: ____________________

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

____
Address 2 (Apartment or Unit #)

____
City, State, ZIP

Phone: ____________________ Email: ____________________

Signatures

Claimant

*Printed Name: ______________________________
First, Middle, Last

*Signature: ______________________________ *Date: ______________
MM/DD/YYYY

Authorized Legal Representative *(if applicable)*:

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 or language interpretation services:
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.