STATE OF CALIFORNIA

Forced or Involuntary Sterilization Compensation Program

Sterilization Statement Form VCB–31–10003 (Rev. 01/2022)

***Required**

*Full Legal Name: ______________________________ *Date: ______________
First, Middle, Last MM / DD / YYYY

Application Number: ______________________________

I, ______________________________ , hereby make the following statement regarding my sterilization or suspected sterilization as resident of, or at, a state hospital, home or institution run by the California Department of State Hospitals or the California Department of Developmental Services or while in custody at a state prison or other correctional facility run by the California Department of Corrections and Rehabilitation:

I declare under penalty of perjury that the information in the statement above, along with any attached page(s), is true to the best of my knowledge or belief.

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 and additional information or documentation 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.