



# OneOrlando Fund

## Physical Injury Victim Application Form

**Deadline for Application:** September 12, 2016

*If you need assistance in completing this form, please call the VictimConnect Resource Center at **855-4-VICTIM** (855-484-2846) or email [OneOrlando@ncvc.org](mailto:OneOrlando@ncvc.org).*

### 1. Victim Information

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Other Names Used: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ SSN/TIN: \_\_\_\_\_

Street Address 1: \_\_\_\_\_

Street Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Country (if other than United States): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Email: \_\_\_\_\_

*Please return this form and all supporting documentation to:*

**National Compassion Fund: OneOrlando**  
c/o National Center for Victims of Crime  
2000 M Street NW, Suite 480  
Washington, DC 20036

CLAIM MUST BE POSTMARKED BY **SEPTEMBER 12, 2016**

## 2. Person Filling out Application *(if not victim)*

If the Claimant is a minor or an incompetent adult, please provide the name, address, and telephone number of the person making this claim for the Claimant. For claims of minors or incompetent adults, please attach **proof of representative capacity**, such as a power of attorney, guardianship, appointment as guardian ad litem, custodial parent, or the equivalent as required by the law of the resident state/province of the incompetent adult or minor.

Relationship to Victim:

Spouse

Parent/Custodial Guardian

Other *(please describe)*: \_\_\_\_\_

Applicant First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_

SSN/TIN: \_\_\_\_\_

Street Address 1 *(if different from victim address above)*: \_\_\_\_\_

Street Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Country *(if other than United States)*: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## 3. Attorney or Other Representation *(if applicable)*

Name: \_\_\_\_\_

Firm: \_\_\_\_\_

Street Address 1: \_\_\_\_\_

Street Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Country *(if other than United States)*: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Alternate Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

#### 4. Physical Injury Description

Please provide a brief description of injuries received on June 12, 2016.

Were you hospitalized overnight as a result of the injuries you sustained during the attack at the Pulse Nightclub on June 12, 2016?

**Yes:** If yes, how many days were you hospitalized due to the events of June 12, 2016? \_\_\_\_\_

Name of Hospital: \_\_\_\_\_

**No:** If no, were you treated on an emergency outpatient basis within 48 hours of the attack?  Yes  No

Name of Hospital/Clinic/Private Physician who treated you: \_\_\_\_\_

*(Please provide proof of treatment with this Application in the form of a hospital or physician statement.)*

#### 5. Supporting Documentation *(please check)*

I have attached the following required documentation:

Proof of Legal Representation

*(If represented by an attorney, please provide a Retention Agreement signed by both the attorney and the claimant.)*

Proof of Relationship to Victim *(if filling out form on behalf of victim):*

Birth Certificate  Marriage License  Other *(please describe):* \_\_\_\_\_

HIPAA Release Form

*(A copy of the form is attached to this Application.)*

Other *(please describe):* \_\_\_\_\_

**6. Payment Preference** *(please select one)*

Check Payable to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Country *(if other than United States)*: \_\_\_\_\_

Electronic Funds Transfer to:

Checking  Savings  Money Market  Other: \_\_\_\_\_

Account No.: \_\_\_\_\_

Routing No.: \_\_\_\_\_

SSN/EIN: \_\_\_\_\_

Bank Name: \_\_\_\_\_

Bank Address: \_\_\_\_\_

Bank Contact: \_\_\_\_\_

Bank Phone: \_\_\_\_\_

**7. Signatures** (to be signed in the presence of a Notary Public)

If the victim is a minor, both parents must sign this form. If both signatures cannot be obtained, please explain why.

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**Claimant Signature**

I hereby certify that the information provided in this claim form is true and accurate to the best of my knowledge. Signature of Claimant on this form does not constitute a waiver of any legal rights. Further, I understand that false statements made in connection with this claim will be forwarded to the appropriate law enforcement agencies for possible investigation.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Notary Signature**

State of: \_\_\_\_\_ County of: \_\_\_\_\_

The foregoing instrument was subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by \_\_\_\_\_.

My Commission expires: \_\_\_\_\_ Affix Seal Here:

Signature of Notary: \_\_\_\_\_

Date: \_\_\_\_\_

**Second Parent Signature** (if applicable)

I hereby certify that the information provided in this claim form is true and accurate to the best of my knowledge. Signature of Claimant on this form does not constitute a waiver of any legal rights. Further, I understand that false statements made in connection with this claim will be forwarded to the appropriate law enforcement agencies for possible investigation.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Notary Signature**

State of: \_\_\_\_\_ County of: \_\_\_\_\_

The foregoing instrument was subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by \_\_\_\_\_.

My Commission expires: \_\_\_\_\_ Affix Seal Here:

Signature of Notary: \_\_\_\_\_

Date: \_\_\_\_\_