ASBESTOS EXPOSURE QUESTIONNAIRE

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CLAIMANT INFORMATION

Provide the claimant's personal details, including their full legal name, date of birth (in DD/MM/YYYY format), and, if deceased, the date of death. Enter the most recent permanent address and postcode, along with the claimant's national identity number or equivalent. Include a telephone number and email address for communication. If the patient is deceased, this section should be completed by the next of kin or executor.

Name of Patient	
Date of Birth	
Date of Death (if deceased)	
Address	
Postcode	
Identity Number	
Telephone Number	
Email Address	

EXECUTOR DETAILS

(Only required if the claimant is deceased and there is an executor managing the estate.)

This section must be completed if the claimant is deceased, and an executor is managing their estate. Provide the executor's full name, company name (if applicable), address, postcode, telephone number, and email. Indicate whether the Letters of Administration have been granted, confirming the executor's legal authority to manage the claim.

Name of Executor	
Company Name	
Address	
Postcode	
Telephone Number	
Email Address	

Have the Letters of Administration been granted?		**Yes**		**No**

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NEXT OF KIN

If the claimant is deceased, provide details of the next of kin, including their full name, relationship to the patient (e.g., spouse, partner, or child), date of birth, address, postcode, and national identity number (attach a copy). Also include their telephone number and email for communication purposes.

Name	
Relationship to Patient	
Date of Birth	
Address	
Postcode	
Identity Number*	
Telephone Number	
Email Address	

*Certified copy of ID is required.

DIAGNOSIS

Indicate the medical condition diagnosed by selecting from Mesothelioma, Lung Cancer, Asbestosis, or Pleural Thickening. Attach copies of medical records confirming the diagnosis and specify the date it was made. If the patient received treatment, provide details including the type of treatment and relevant dates.

Have you been or was the patient diagnosed with one of the following conditions?*							
	Mesothelioma		Lung Cancer		Asbestosis		Pleural Thickening
Please specify:							
Date of Diagnosis							
Are you currently receiving or did the patient receive any treatment?					Yes		No
If so, please provide details:							
Nature of Treatment							
Date(s) of Treatment							

*Please provide copies of any medical records which confirm the diagnosis.

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MEDICAL FACILITIES

List all hospitals, clinics, and healthcare professionals involved in the diagnosis and treatment of the condition. Include the name of the medical facility, contact details (phone/email), and the names of the doctors who provided care.

Name of Practice/Hospital	Contact Details (Email/Phone)	Names of Doctor(s) Seen

EXPOSURE

Complete only the section relevant to how the claimant was exposed to asbestos. If exposure occurred at work, provide the employer's name, asbestos mine/mill name (if applicable), job role, years of employment, and details of exposure. If exposure resulted from living near an asbestos mine/mill, provide the mine/mill name, location, home/work address at the time, distance from the site, years of exposure, and details on how the asbestos dust was encountered. If exposure happened through another source, describe how and where the exposure occurred, including the frequency and any additional relevant information.

Name of Employer	
Name of Asbestos Mine/Mill	
Years of Employment	
Job Role/Title	
Details of/Source of Exposure	

Name of Employer	
Name of Asbestos Mine/Mill	
Years of Employment	
Job Role/Title	
Details of/Source of Exposure	

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ENVIRONMENTAL EXPOSURE

(Living Near an Asbestos Site)

Name of Asbestos Mine/Mill	
Location of Asbestos Mine/Mill	
Distance between Asbestos Mine/Mill and Home/Work Address	
Years of Exposure from Asbestos Mine/Mill	

Please provide details of how the patient was exposed to asbestos from living in close proximity to the asbestos mine or mill. Please include such information as: i) The source of asbestos dust. ii) How the patient came into contact with asbestos dust. iii) The regularity with which the patient was exposed. iv) Any other relevant information:

OTHER SOURCES OF EXPOSURE

Please provide details of how the patient was exposed to asbestos from another source. Please include such information as: i) The source of asbestos dust. ii) How the patient came into contact with asbestos dust. iii) The regularity with which the patient was exposed. iv) Any other relevant information:

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FAMILY INFORMATION

Provide details of the claimant's immediate family, including their full legal names and dates of birth. If any family members are deceased, include their date of death. List the claimant's father and mother, along with their birth and death dates (if applicable). Include the names and birth dates of any children and siblings, noting any who have passed away. Ensure all information is accurate, as it may be used for verification in legal or compensation claims.

Father's Name	
Date of Birth	
Date of Death	
Mother's Name	
Date of Birth	
Date of Death	
Children's Name	
Date of Birth	
Date of Death	
Children's Name	
Date of Birth	
Date of Death	
Sibling's Name	
Date of Birth	
Date of Death	
Sibling's Name	
Date of Birth	
Date of Death	

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APPLICATION FOR COMPENSATION

If the claimant has applied for compensation, provide details of the trust fund(s) they applied to, including the date of application and outcome. If an application was made under the Compensation for Occupational Injuries and Diseases Act (COIDA) or any other legal route, include the dates and results. If the claimant has pursued other legal action or claims, provide relevant details.

Has the patient made an application for compensation from a trust?		**Yes**		**No**
If so, please specify which trust(s):				
What date was the application made?				
Was the application successful?		**Yes**		**No**
Has the patient made an application for compensation under the Compensation for Occupational Injuries and Disease Act 1993 (or COIDA Scheme)?		**Yes**		**No**
What date was the application made?				
Was the application successful?		**Yes**		**No**
Has the patient made an application for compensation from any other source or taken any other legal advice?		**Yes**		**No**
If so, please provide details:				

ADDITIONAL INFORMATION

Use this section to provide any other relevant details that may support the claim, such as witness statements, additional medical records, historical documents, or specific challenges in obtaining information.

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FINAL DECLARATION AND STATEMENT OF TRUTH

STATEMENT OF TRUTH

By signing below, you confirm that the information provided in this questionnaire is true and accurate to the best of your knowledge and belief. You understand that providing false or misleading information may affect the validity of any claim.

Signed	
Name	
Date	

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