SCHEDULE 3 TO
PROTOCOL FOR COVAX NO-FAULT COMPENSATION PROGRAM FOR AMC ELIGIBLE ECONOMIES

SUPPORTING EVIDENCE FORM

INSTRUCTIONS / IMPORTANT NOTICES FOR APPLICANTS AND REGISTERED HEALTHCARE PROFESSIONALS:

1. Definitions: For the meaning of capitalized terms used in this form, such as for example "Applicant", "Injury", "Vaccine", "AMC Eligible Economy", "Registered Healthcare Professional", "Patient", etc., please consult the Program Definitions, available at www.covaxclaims.com.
2. When and How to Use this Form: This Supporting Evidence form should be completed by one or more Registered Healthcare Professionals[1], and not by the Applicant. This Supporting Evidence form should be used to provide the medical evidence that is required as indicated in Section 8(a) of the Application form (Schedule 2 of the Program's Protocol). An Applicant can submit an application for compensation under the Program if he/she (or the person he/she represents) has suffered an Injury following the administration of a Vaccine in an AMC Eligible Economy. To find out which are the AMC Eligible Economies covered by the Program, please refer to the list under Question 5 of the Program's Frequently Asked Questions (available at www.covaxclaims.com). To file an application for compensation under the Program, the Applicant should submit this Supporting Evidence form together with the Application form.
3. Waiting period: Please note that except if the person which the Applicant represents has died, the Applicant should wait 30 days following the administration of the Vaccine dose that is deemed to have resulted in the Injury, before asking one or more Registered Healthcare Professionals to complete this Supporting Evidence form.
4. Accepted Languages**:** This Supporting Evidence form must be completed in English, French or Spanish only, and not in any other language. Any documents that are required to be provided with this form can however be submitted in another language, if they are not available in either English, French or Spanish.
5. Completeness: One or more Registered Healthcare Professionals should complete this form as much as possible, and provide as much information as possible. Each of the Registered Healthcare Professional(s) completing this Supporting Evidence form should sign, date and insert his/her full name in Section 2 of this form.
6. Attachments to this Form: Registered Healthcare Professionals may answer questions in this Supporting Evidence form by referring to documents they provide with this form. The information contained in the documents provided with this form does not need to be repeated in the answers provided in the form itself.
7. Deadline for Submission: Please note that there is a deadline for the Applicant to submit his/her application documents (i.e., the fully completed Application (Schedule 2) and Supporting Evidence (Schedule 3) forms together with the required accompanying documents) to the Program. These application documents should be submitted in the Reporting Period that applies to the Applicant (or the person the Applicant represents). If you need help with determining what is the Reporting Period in which the Applicant (or the person the Applicant represents) should submit the application documents, please contact the Program's relevant Regional Center by email, telephone or regular mail, or the Program's Administrator by email at covaxclaims@esis.com. If the Applicant submits this Supporting Evidence form after the end of the Reporting Period, this application may not be accepted. Please also note that the Program's application process will come to an end on 30 June 2027. No application can be submitted after this date.
8. Contact Information for the Program: If you (the Registered Healthcare Professional) have any questions or need assistance in completing this Supporting Evidence form, you can contact the Program as indicated in Annex 1.

[1] The term "Registered Healthcare Professional" means any healthcare professional, including physicians, surgeons, nurses, midwives, nurse practitioners, physicians' assistants, psychiatrists, physical therapists, occupational therapists, dentists and pharmacists, who is duly licensed or legally authorized to practice the profession in the AMC Eligible Economy in which the Patient resides or received the Vaccine or in the case of birth defects, where the Patient's mother resides or received the Vaccine.

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IMPORTANT NOTE FOR COMPLETING THIS FORM: You may answer questions in this Supporting Evidence form by referring to documents (such as medical reports) that you are providing with this form. The information contained in the documents provided with this form does not need to be repeated in the answers provided in the form itself.

1. REPORT OF REGISTERED HEALTHCARE PROFESSIONAL(S)

A. INFORMATION ABOUT THE PATIENT[2]	
Full name of the Patient, including any middle names	
Mailing address of the Patient (including city, zip code and country)	
Date of birth of the Patient (day/month/year)	
Gender of the Patient	
B. INFORMATION ABOUT THE REGISTERED HEALTHCARE PROFESSIONAL(S) COMPLETING THIS FORM	
1. Full name(s), including any middle names, of the Registered Healthcare Professional(s) completing this Supporting Evidence form.	
2. Name of the hospital, clinic or other place of work of Registered Healthcare Professional(s) completing this form, including: (A) mailing address(es), (B) email address(es), and (C) telephone number(s).	

[2] The term "Patient" means an individual : (i) who is a citizen, resident, or person within the populations of concern to the COVAX Humanitarian Buffer, as defined and updated from time to time by the Inter-Agency Standing Committee (IASC), in an AMC Eligible Economy: (ii) who was administered a Vaccine in an AMC Eligible Economy; and (iii) who claims or in respect of whom it is claimed that he suffered or sustained a Serious Adverse Event which is associated with a Vaccine or its administration, and which, in turn, has resulted in an Injury. Injury means a serious bodily injury or illness suffered or sustained by a Patient that:

(i) results in permanent total or partial Impairment; or
(ii) is a congenital birth injury or illness in an unborn or new-born child of a woman who received a Vaccine and results in permanent total or partial Impairment; or
(iii) results in death.

3. Type of registration held by the Registered Healthcare Professional(s) completing this form, together with the registration number(s) or other means to identify the registration(s). For example, if you are a state registered nurse, please state "nurse" and provide your registration number.

C. INFORMATION ABOUT THE VACCINE ADMINISTERED TO THE PATIENT (OR IN THE CASE OF BIRTH DEFECTS, TO THE PATIENT'S MOTHER)

<u>IMPORTANT NOTES</u>:

- **IF THE VACCINE IS A ONE DOSE SCHEDULE VACCINE, PLEASE PROVIDE BELOW THE DETAILS FOR THE SINGLE DOSE IN QUESTION.**
- **IF THE VACCINE IS A TWO DOSE SCHEDULE VACCINE, PLEASE INDICATE BELOW WHETHER BOTH DOSES OF THE VACCINE HAVE BEEN ADMINISTERED TO THE PATIENT (OR IN THE CASE OF BIRTH DEFECTS, TO THE PATIENT'S MOTHER), AND IF SO, PROVIDE THE DETAILS FOR BOTH DOSES.**
- **IF ANY ADDITIONAL DOSE(S) AND/OR A BOOSTER DOSE(S) HAS/HAVE BEEN ADMINISTERED TO THE PATIENT (OR IN THE CASE OF BIRTH DEFECTS, TO THE PATIENT'S MOTHER) IN ADDITION TO THE ORIGINAL ONE OR TWO DOSE SCHEDULE, PLEASE ALSO PROVIDE THE DETAILS REGARDING SUCH ADDITIONAL OR BOOSTER DOSE(S).**

1. Details of **each dose** of the Vaccine administered to the Patient (or in the case of birth defects, to the Patient's mother), including the Vaccine's: (A) name, (B) dose(s), (C) batch or lot number(s), and (D) expiry date(s).

2. If known, details of diluent (if any) used with **each dose** of the Vaccine administered to the Patient (or in the case of birth defects, to the Patient's mother), including the diluent's: (A) name, (B) dose(s), (C) batch or lot number(s), and (D) expiry date(s).

3. Date(s) and location(s)/place(s) (for example, health facility) where each of the Vaccine dose(s) was/were administered to the Patient or in the case of birth defects, to the Patient's mother. If the Vaccine was administered at a mobile vaccination unit, please state "mobile vaccination unit in ……." [include name of the town or village]. Please state the date(s) for each of the doses administered as day/month/year.

4. To the extent known, please indicate if the Vaccine dose(s) that was/were administered to the Patient (or in the case of birth defects, to the Patient's mother) was/were used in accordance with that Vaccine's label[3].

   Yes _____ No _____ Unknown _____ (check only one answer)

   If "no", provide full details of how the use of the Vaccine deviated from the Vaccine's label.

[3] Please note that if the government of the country has authorized, recommended or permitted the use of the Vaccine in a manner other than in accordance with that Vaccine's label, Serious Adverse Events arising from such use may still be eligible for compensation under the Program. As provided in Section 1 (b) of the Program's Protocol, in the event a government of any AMC Eligible Economy authorizes, recommends or permits the use of a Vaccine in a manner other than in accordance with that Vaccine's label, then Serious Adverse Events arising from such use of the Vaccine shall be eligible for compensation under the Program (subject to and in accordance with the Program's Protocol), if and to the extent this use complies with the recommendations of the WHO Strategic Advisory Group of Experts on Immunization (SAGE) and WHO guidance relating to the implementation of such recommendations.

D. INFORMATION ABOUT THE INJURY OR ILLNESS SUSTAINED BY THE PATIENT (OR, IN THE CASE OF BIRTH DEFECTS, BY THE PATIENT MOTHER) AFTER THE VACCINE DOSE(S) WAS/WERE ADMINISTERED TO THE PATIENT (OR IN THE CASE OF BIRTH DEFECTS, TO THE PATIENT'S MOTHER).

IMPORTANT NOTE: IF A PATIENT HAS DIED, PLEASE COMPLETE THIS SECTION D TO THE EXTENT APPLICABLE, IN ADDITION TO COMPLETING SECTION E.

1. If more than one does of the Vaccine has been administered, please indicate after which Vaccine dose (first, second, booster, etc.) the injury or illness was suffered by the Patient

2. Please describe the injury or illness suffered by the Patient after the Vaccine dose(s) was/were administered to the Patient (or in the case of birth defects, to the Patient's mother). Please include:
   (A) details of all examinations and tests of the Patient in relation to such injury/illness; and
   (B) if applicable, details of any congenital birth injury or illness.

3. Regarding symptoms, please describe the following:
   (A) all symptoms experienced by the Patient after each of the Vaccine dose(s) was/were administered to the Patient (or in the case of birth defects, to the Patient's mother);
   (B) the dates (day / month / year) when the symptoms first occurred
   (C) the dates (day / month / year) when the symptoms were first reported (if different from the date in (B) above; and
   (D) for each symptom, the extent to which that symptom was serious; and

(E) the details of any sequelae (outcome or development of the injury/ illness, including any related health consequences).

In particular, please mention:

- any severe local reaction suffered by the Patient or, in the case of birth defects, by the Patient's mother, after each of the Vaccine dose(s) administered to him/her or in the case of birth defects, to the Patient's mother (and whether that reaction extended beyond nearest joint); and
- any seizures (febrile or afebrile), abscess, sepsis, encephalopathy, toxic shock syndrome, thrombocytopenia, anaphylaxis, fever (above 38 degrees centigrade).

4. Did the Patient require any treatment for the injury or illness suffered by the Patient after the Vaccine dose(s) was/were administered to him/her (or in the case of birth defects, to the Patient's mother)?

If "yes", please describe what treatment was provided to the Patient for the injury/illness suffered by the Patient after the Vaccine dose(s) was/were administered to him/her (or in the case of birth defects, to the Patient's mother).

Please provide the above information separately for each of the Vaccine doses administered.

5. Please describe to what extent the Patient has or has not (as applicable) recovered from the injury/ illness suffered by the Patient after the Vaccine dose(s) was/were administered to him/her (or in the case of birth defects, to the Patient's mother).
   Please provide the above information separately for each of the Vaccine doses administered.

6. In your opinion, was/were the Vaccine dose(s) administered to the Patient (or in the case of birth defects, to the Patient's mother) the cause of the injury or illness suffered by the Patient? If not, please indicate what was in your opinion the cause of the injury.

7. If known, please provide the date (day/month/year) and place when the injury or illness suffered by the Patient was first reported to a Registered Healthcare Professional or to the health system.

8. Describe the extent of any permanent impairment (disability) of the Patient and the prognosis for the Patient as a result of such impairment (disability).

9. How has the injury or illness suffered by the Patient after the Vaccine dose(s) was/were administered to him/her (or in the case of birth defects, to the Patient's mother) impacted (affected) the daily functioning of the Patient?

10. Details of any hospitalization, or prolongation of existing hospitalization, of the Patient for more than 24 consecutive hours in connection with the injury or illness suffered by the Patient after the Vaccine dose(s) was/were administered to the Patient (or in the case of birth defects, to the Patient's mother), including:

    (A) Date(s) (day/month/year) when the Patient was admitted to the hospital or when the Patient's existing hospitalization was prolonged;

    (B) Date(s) (day/month/year) when the Patient was discharged from the hospital; and

    (C) Type of care/treatment provided to the Patient during the hospitalization or prolongation of existing hospitalization for the injury or illness suffered by the Patient after the Vaccine dose(s) was/were administered to him/her (or in the case of birth defects, to the Patient's mother).

11. Details of other medication/vaccination, to the extent known:

(A) Please list all of the medicines taken (if any) by, and/or any other (non-COVID-19) vaccines administered to, the Patient after the Vaccine dose(s) was/were administered to the Patient and/or during the period of 6 weeks before the administration of each Vaccine dose, including:
- name of each medicine/vaccine;
- dose
- time period taken or /administered (stated as day/month/year)

Please provide this information separately for each of the Vaccine doses administered.

(B) In the case of birth defects, please list all of the medicines taken (if any) by, and/or any other (non-COVID-19) vaccines administered to, the Patient's mother during the pregnancy and/or 6 weeks before the start of the pregnancy, including:
- name of each medicine/vaccine;
- dose;
- time period taken or /administered (stated as day/month/year)

Please provide this information separately for each of the Vaccine doses administered.

12. **Details of previous long-term medication, to the extent known.** Please list any medicines and/or medical therapies (e.g. chemotherapy or radiation therapy) not listed above that were taken and/or undergone by the Patient (or in the case of birth defects, the Patient's mother) for a consecutive period of more than 3 weeks, during the 24 months before each of the Vaccine dose(s) was/were administered to the Patient (or in the case of birth defects, the Patient's mother), including:
- name of each medicine and/or medical therapy;
- dose;
- time period taken (stated as day/month/year).

13. Please describe any known pre-existing medical conditions of the Patient (or in the case of birth defects, any pre-existing medical conditions of the Patient's mother). Pre-existing medical conditions are medical conditions existing before each of the Vaccine dose(s) was/were administered to the Patient or in the case of birth defects, to the Patient's mother.

14. To the extent known, please also indicate whether and if so for what medical condition(s), the Patient (or in the case of birth defects, the Patient's mother) has been treated by a healthcare provider during the 24 months before each of the Vaccine dose(s) was/were administered to the Patient (or in the case of birth defects, the Patient's mother). Please provide the name, address and telephone number of the healthcare provider(s) in question, if available.

15. Has the Patient suffered any similar injury or illness before? If "yes", please describe the previous similar injury or illness.

16. In the case of birth defects, did the Patient's mother have another unborn or new-born child with a congenital birth injury or illness? If "yes", please provide details.

17. In your opinion, is it possible that the injury or illness suffered by the Patient after the Vaccine dose(s) was/were administered to the Patient (or in the case of birth defects, to the Patient's mother) was caused by, or resulted from, any previous injury or illness of the Patient (or in the case of birth defects, of the Patient's mother)?
If "yes", please provide details.

18. To the extent known, has a close family member of the Patient, such as brother, sister, parent, child, aunt, uncle, or 1st cousin, suffered any similar injury or illness before?
If "yes", please indicate which close family member and describe the similar injury or illness.

19. In the case of birth defects, and to the extent known, did a close relative of the Patient's mother have an unborn or new-born child with a congenital birth injury or illness? If "yes", please provide details.

20. Have you seen any injury or illness similar to that suffered by the Patient amongst other patients who received (or in the case of birth defects, whose mother received) the same Vaccine?

E. IF THE PATIENT HAS DIED, INFORMATION ABOUT THE PATIENT'S DEATH:

1. If the Patient has died after the Vaccine dose(s) was/were administered to the Patient (or in the case of birth defects, to the Patient's mother), then please:
   a. State date of the Patient's death (day/month/year) and all causes of death stated on the Patient's death certificate; and
   b. Include the details of any autopsy performed on the Patient.

2. In accordance with Section G below, please provide a copy of the Patient's death certificate and any other documentation available regarding the cause and manner of the Patient's death.

3. In your opinion, what is/are the causes(s) of the Patient's death?

4. Have you seen death similar to that suffered by the Patient among other patients who received the same Vaccine as the Patient (or in the case of birth defects, whose mothers received the same Vaccine as the Patient's mother)? If "yes", please provide details.

F. OTHER INFORMATION:
Please set out any further information which you consider may be relevant for the Patient's claim for compensation under the Program
G. DOCUMENTATION TO BE PROVIDED WITH THIS FORM
1. Please provide documentation confirming that the Vaccine dose(s) was/were administered to the Patient (or in the case of birth defects, to the Patient's mother), for example, a copy the immunization card or certificate, a copy of the service point immunization log(s) documenting the administration of the Vaccine dose(s), or a copy of the completed national Adverse Event Following Immunization (AEFI) investigation form 2. Please attach a copy of all available medical documentation and records related to the injury or illness sustained by the Patient after administration of the Vaccine dose(s) to the Patient or in the case of birth defects, to the Patient's mother, including case sheet, case notes, discharge summary, laboratory reports, autopsy report, as well as prescriptions for concomitant and/or long-term medication, as referred to above, etc. 3. If available, please also attach a copy of the AEFI investigation form, AEFI committee causality assessment, and related documentation.[4]

2. DECLARATION AND SIGNATURE OF REGISTERED HEALTHCARE PROFESSIONAL(S)

By signing below, I/we hereby certify that:

- before this Supporting Evidence form was completed, a waiting period of 30 days has been observed since the administration of the Vaccine dose that is deemed to have resulted in the Injury (except in the case of death of the Patient, in which case this waiting period does not apply); and

- the statements and answers contained in this Supporting Evidence form are true and correct to the best of my/our knowledge and belief.

I/We understand that should these statement or answers not be true, the Administrator shall have the right,

[4] AEFI investigations and causality assessments may be conducted by a Ministry of Health, its national immunization program, or associated committees, and documents related to such investigations and assessments may be available from such groups.

where applicable, to refer to the relevant law enforcement authority for further investigation.

Full Name of Registered Healthcare Professional: _____

Title: _____

Signature: _____

Date: _____

Full Name of Registered Healthcare Professional: _____

Title: _____

Signature: _____

Date: _____

Annexes:

Annex 1 – Contact Information for the Program's Regional Centers

SCHEDULE 3 TO
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ANNEX 1

CONTACT INFORMATION FOR REGIONAL CENTERS UNDER THE COVAX NO-FAULT COMPENSATION PROGRAM FOR AMC ELIGIBLE ECONOMIES (THE "PROGRAM")

In the table below, you can find the names, addresses, email addresses and direct (at-cost) telephone numbers of the various Program Regional Centers. There is also a Global Telephone Hotline for the Program, which is 1-833-276-8262. The telephone number for the Global Telephone Hotline may be toll-free or at-cost to you, depending on which AMC Eligible Economy you are calling from. You should verify whether or not any calling charges apply before calling the Global Telephone Hotline.

If you have any questions about the Program or need help in completing this Supporting Evidence Form you can contact the Regional Center allocated to (i) the country where the Patient (or in the case of birth defects, the Patient's mother) has been vaccinated, or (ii) the country of residence of the Applicant or the Patient (or in the case of birth defects, the Patient's mother).

The Program's Regional Centers are available to assist you in your native language, as well as in English, French or Spanish. If you have any questions or need help, please contact the allocated Regional Center by email, telephone or regular mail using the contact information provided in the table below, and the Regional Center will do its best to assist you in your native language.

IMPORTANT NOTE: Each Regional Center listed below services only those AMC Eligible Economies that are listed on the right side of that Regional Center. Please ensure that you only contact the correct Regional Center—i.e., the Regional Center that services the AMC Eligible Economy in which the Vaccine was administered to the Patient (or in the case of birth defects, the Patient's mother) or that services the AMC Eligible Economy of residence of the Applicant or the Patient (or in the case of birth defects, the Patient's mother).

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Regional Center Contact Information	AMC Eligible Economies Serviced by the Regional Center				
South Africa Crawford & Company PO Box 782023 Sandton 2146 South Africa **+27 (0)11 463 5900** Covaxclaims.SouthAfrica@crawford.com	1. Angola 2. Benin 3. Burkina Faso 4. Burundi 5. Cabo Verde 6. Cameroon 7. Central African Republic 8. Chad	9. Comoros 10. Congo, Dem Rep. 11. Congo Rep. 12. Côte d'Ivoire 13. Djibouti 14. Eritrea 15. Eswatini 16. Ethiopia 17. Gambia	18. Ghana 19. The Guinea 20. Guinea-Bissau 21. Kenya 22. Lesotho 23. Liberia 24. Madagascar 25. Malawi 26. Maldives	27. Mali 28. Mauritania 29. Mozambique 30. Niger 31. Nigeria 32. Rwanda 33. Sao Tome & Principe 34. Senegal	35. Sierra Leone 36. Somalia 37. South Sudan 38. Sudan 39. Tanzania 40. Togo 41. Uganda 42. Zambia 43. Zimbabwe
Australia Crawford & Company GPO Box 1016, Brisbane QLD 4004 Australia **+61 7 3223 3100** Covaxclaims@crawco.com.au	44. Fiji 45. Kiribati 46. Marshall Islands 47. Micronesia, Federated States 48. Papua New Guinea			49. Samoa 50. Solomon Islands 51. Tonga 52. Tuvalu 53. Vanuatu	
Germany Crawford & Company Werdener Strasse 4, 40227 Düsseldorf Germany **+49 211 95456250** Covaxclaims@crawco.de	54. Kosovo 55. Kyrgyz Republic 56. Moldova 57. Tajikistan 58. Ukraine 59. Uzbekistan				
Mexico Crawford & Company de México, S.A. DE C.V. Miguel Laurent No. 17 Piso, 601. Colonia Del Valle, Alcaldia Benito Juarez Ciudad De México C.P. 03200	60. Dominica 61. El Salvador 62. Grenada 63. Guyana 64. Haiti			65. Honduras 66. Nicaragua 67. St. Lucia 68. St. Vincent and the Grenadines	

Mexico **+52 55 5093 6467** Covaxclaims.Mexico@crawford.com		
Brazil Crawford & Company Geraldo Flausino Gomes, 78 14º Andar Cidade Monções 04575-060 São Paulo Brazil **+55-11-3879-7500** Covaxclaims.Brazil@crawford.com	69. Bolivia	
Singapore Crawford & Company 8 Shenton Way #03-01, AXA Tower Singapore 068811 Singapore **+65 6632 8639** Covaxclaims.Singapore@crawford.asia	70. Cambodia 71. Indonesia 72. Korea, Dem. People's Rep. 73. Lao PDR	74. Myanmar 75. Timor-Leste 76. Vietnam
Hong Kong Crawford & Company 24/F Sunshine Plaza, 353 Lockhart Rd, Wanchai Hong Kong **+852 2526 5137** Covaxclaims.HongKong@crawford.asia	77. Mongolia 78. Philippines	
United Arab Emirates Crawford & Company P.O. Box 2976 Dubai, United Arab Emirates	79. Egypt, Arab Rep. 80. Syrian Arab Rep. 81. Yemen, Rep.	

+971 4 345 9541 Covaxclaims@crawco.me	
India Puri-Crawford Unit No.1, First floor, Windsor Terrace, Above Hotel Samruddhi, Vishrantwadi, Pune, Maharashtra 411015 India **+91 (020) – 26612524** Covaxclaims.India@crawford.com	82. Afghanistan 83. Bangladesh 84. Bhutan 85. India 86. Nepal 87. Pakistan 88. Sri Lanka
Israel Crawford-Tossman No. 2 Choma Umigdal St., Tel Aviv, Israel, 6777102 **+972 35 628 811** Covaxclaims.Israel@crawford.com	89. West Bank and Gaza
Belgium Crawford & Company Jan Olieslagerslaan 41 1800 Vilvoorde Belgium **+32 2 257 03 52** Covaxclaims@crawco.be	90. Algeria 91. Morocco 92. Tunisia

[END OF THE SUPPORTING EVIDENCE FORM]