CAMP LEJEUNE

The Legal Leads

LEAD INFORMATION

Full name:

Phone: **E-mail:** **Best Contact Time:**

DOB of injured party:

D D M M Y Y Y Y

Address :

CONTACT INFORMATION

Calling For: **Name of claimant (if calling for someone else):**

Relationship: **Deceased?** ☐ Yes ☐ No

Relationship to the deceased: **Deceased state**

Date Deceased: D D M M Y Y Y Y

Emergency Contact Name: **Emergency Contact Phone:** **Emergency Contact Relationship:**

INTAKE

What dates did you serve, work, reside, or were otherwise exposed to water at Camp Lejeune:

Did claimant live or work for at least 30 days at Camp Lejeune between 1895 and 1987? ☒ Yes ☐ No

Reason for stay (Military, Military dependent, Civilian employee):

Job description/employer info:

Is the claimant a military veteran? ☐ Yes ☐ No

Receiving VA medical benefits for this injury? If yes, explain: ☐ Yes

Receiving VA checks for any other conditions? If yes, explain: ☐ Yes

Type of Injury:

Filed claim with Dept. of the Navy regarding this matter? ☐ Yes ☐ No

When 1st exposed: D D M M Y Y Y Y

When last exposed: D D M M Y Y Y Y

When diagnosed: D D M M Y Y Y Y

Where diagnosed name:

Where diagnosed address:

Treatment Date: D D M M Y Y Y Y

Where treated name:

Where treated address:

Call recording link: