



(file: Application V1)



Port Hope Radiobiological Studies Project **April 2005**

A joint project of the
Port Hope Community Health Concerns Committee (PHCHCC)
and
Uranium Medical Research Centre (UMRC)

Application for Consideration

This application has been developed for use by individuals who have reason to believe that they may have been contaminated by uranium as a result of living, working or spending time in Port Hope, Ontario and wish to apply to participate in the Port Hope Radiobiological Studies Project. Exposure and contamination may have occurred as a result of inhalation, skin absorption or ingestion of uranium and uranium compounds present in the environment or any facility in Port Hope. It may be current, recent or historical exposure caused by current, recent or historical events, locations or materials.

If you are eligible, you will proceed through the following steps:

1. Intake Interview
2. Clinical Assessment
3. Uranium Bioassay

Your application will be reviewed by the project staff. We will contact you to discuss your eligibility for proceeding to a clinical assessment and uranium bioassay. If accepted you will receive a clinical assessment by a physician specializing in internal contamination by radio nuclides. A 24-hour specimen of your urine will be collected and examined in a mass-spectrometry laboratory to determine if you are excreting unusual quantities (abundance) and or types (isotopes) of uranium. You will receive a bioassay report explaining the lab results and their interpretation. A consultation can be provided to your personal physician. Patient participants may be offered an opportunity to participate in follow-on studies of internal contamination effects.

The clinical data from all participants in the study will be used in scientific papers, which will be submitted for review by other scientists, physicians, presented at scientific conferences and published. The identity of all patients and study participants will be kept confidential. As a participant in the project you are deemed a patient of UMRC's consulting physicians and you are protected by the rules of doctor-patient confidentiality.

The Port Hope Community Health Concerns Committee will use the study results / data and UMRC's analysis of the data for purposes of public information and planning. The identity of all participants and patients will be kept confidential to the project team. Selected project staff members designated within the PHCHCC executive may have access to individual patient information under the auspices of UMRC's physicians. Patients can choose to reveal their own identities publicly or to others.

I would like to know if I am contaminated and I wish to participate

You may contact the Port Hope Community Health Concerns Committee (PHCHCC) to discuss applying to the Radiobiological Studies Project being offered by the Committee and the Uranium Medical Research Centre (UMRC), by sending an e-mail to the address below or you may proceed to submit a completed application in writing to the Committee at the address provided.

How to contact

The Port Hope Community Health Concerns Committee (PHCHCC)

Mail

Port Hope Community Health Concerns Committee

Station Main

P.O. Box 476,

Port Hope, Ontario.

L1A 3Z3

Website - www.porthopehealthconcerns.com

Email - info@porthopehealthconcerns.com

Port Hope Radiobiological Studies Project 2005

Application for Consideration

Section A - Contact Information			
1.	Name (please print):		
2.	Date of Birth: m / d / yr	3.	Gender: (circle) F M
4.	Address:		
5.	Town/City:		
6.	Province / State / Other:	7.	Country:
8.	Phone (day):	9.	Phone (evening):
10.	E-mail:	11.	Fax:

Section B – Applicant Identification	
I am completing this for:	
1.	<input type="checkbox"/> myself (please print name)
2.	<input type="checkbox"/> a family member or friend (please print name)
3.	Identify relationship to applicant:

Section C - Reason for Application	
I am applying because of:	
1.	<input type="checkbox"/> Possible or known exposure to radioactive contaminants.
2.	<input type="checkbox"/> Health concerns past or present.
3.	<input type="checkbox"/> Unexplained illness in self, family, friends and / or neighbours.
4.	<input type="checkbox"/> Other, please provide details:
5.	Please explain briefly, the reasons for applying:

Section D - Residential History	
1.	I live or lived in Port Hope, Ontario (Wards 1 and 2). Yes <input type="checkbox"/> No <input type="checkbox"/>
2.	I was born in Port Hope, Ontario (Wards 1 and 2). Yes <input type="checkbox"/> No <input type="checkbox"/>
3.	I am a child of a resident from Port Hope, Ontario (Wards 1 and 2). Yes <input type="checkbox"/> No <input type="checkbox"/>
4.	If yes to <u>any of the above questions</u> , please estimate total years of residency in Port Hope (Wards 1 and 2)._____years.

Section E - Occupational History

1.	I work or worked in Port Hope, Ontario (Wards 1 and 2). Yes <input type="checkbox"/> No <input type="checkbox"/>
2.	If yes, briefly describe nature of work, specific locations and facilities:
3.	If you worked in an industry handling radioactive materials, please specify nature of the work, locations, facilities:
4.	Did you do sub-contract or occasional work with an industry handling radioactive materials in Port Hope, Ontario (Wards 1 and 2). Yes <input type="checkbox"/> No <input type="checkbox"/>
5.	If yes, briefly describe nature of the work, locations worked/visited, and facility employed:
6.	Did you work in a place/s where radioactive material or equipment was on site, handled, stored, cleaned, repaired or transported, discarded, recycled? Yes <input type="checkbox"/> No <input type="checkbox"/>
7.	If yes, please provide details:

8.	<p>Did you work or visit where nuclear materials, radioactive metals, scrap etc, were melted, turned, punched, extruded, braised, etched, welded, cut, “ground”, mixed with other materials or compounds etc? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
9.	<p>If yes, please provide details:</p>
10.	<p>If yes to <u>any of the above questions</u>, please estimate total months and years of exposure to radioactive materials in Port Hope (Wards 1 and 2). _____months, _____ years.</p>
11.	<p>Did any members of your family visit or work in locations or facilities (indoors or outdoors) where radioactive materials or equipment were on site, handled, stored, cleaned, repaired or transported. Yes <input type="checkbox"/> No <input type="checkbox"/></p>
12.	<p>If yes please provide details:</p>
13.	<p>Did you work, live or visit locations, facilities or communities other than Port Hope where you may have been or were knowingly exposed to radioactive materials? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
14.	<p>If yes, please provide details (locations and length of exposure in months):</p>

Section F - Port Hope Recreational History

1.	Did you or any members of your family spend recreational time in specific locations or facilities in Port Hope (Wards 1 and 2) that have required remediation for the presence of radioactive wastes or are near such areas or waste sites? Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> (i.e.: West Beach area, East Beach area, Yacht Club area, Lion's Recreation Centre, Jack Burger Sports Complex, Town Park (Ward St.), Monkey Mountain/Highland Drive area, Welcome dump area, Marsh Road, Lakeshore Road, Strachan Street Ravine, Rollins Ravine, on or near truck routes for waste)
2.	If Yes, please provide details:
3.	Please estimate total of months of possible exposure you spent in these recreational Areas. _____ months.

Section G - Exposure History

1.	Do you know or believe you were exposed to radioactive materials in Port Hope, Ontario (Wards 1 and 2) during a specific incident, event or location? Yes <input type="checkbox"/> No <input type="checkbox"/> (i.e.: spills, fires, air release, construction activities, walking or playing on truck routes, fishing, gardening, at school, hiking, visiting dumps or landfills)
2.	If yes, please provide details:

Section H - Specific Health Concerns	
1.	Do you have any health concerns that you believe may be due to exposure to radioactive materials? Yes <input type="checkbox"/> No <input type="checkbox"/>
2.	If yes, please explain:
Section H Part I – Effects of acute and incidental exposure to uranium	
Please check those symptoms and conditions that apply to you now or have in the past that have an unexplained origin.	
1.	<input type="checkbox"/> Nose bleeds and/or runny nose.
2.	<input type="checkbox"/> Irritation and stinging sensations in throat, nasal passages, mouth.
3.	<input type="checkbox"/> Skin and/or eyes irritated and burning.
4.	<input type="checkbox"/> Skin and/or eyes burning when water is applied.
5.	<input type="checkbox"/> Dry, upper respiratory cough.
6.	<input type="checkbox"/> Cold and flu - like symptoms lasting for weeks.
7.	<input type="checkbox"/> Unusual tiredness, fatigue, weakness (disabling fatigue).
8.	<input type="checkbox"/> Intermittent fevers.
9.	<input type="checkbox"/> Sweating at night.
10.	<input type="checkbox"/> Headaches.
11.	<input type="checkbox"/> Recurring or continuous pain in joints.
12.	<input type="checkbox"/> Recurring nerve, muscle and soft tissue pain.
13.	<input type="checkbox"/> Short-term memory loss, inconsistent memory capacity.
14.	<input type="checkbox"/> Mental confusion and disorientation.
15.	<input type="checkbox"/> Depression and loss of initiative.
16.	<input type="checkbox"/> Chest pain.
17.	<input type="checkbox"/> Chronic cold or flu consistent with respiratory symptoms.

18.	<input type="checkbox"/>	Asthma, chronic bronchitis.
19.	<input type="checkbox"/>	Frequent or persistent unproductive dry cough.
20.	<input type="checkbox"/>	Pain in neck, basal skull area, cervical column.
21.	<input type="checkbox"/>	Lower-back, kidney pain.
22.	<input type="checkbox"/>	Stinging sensation when urinating, ejaculating.
23.	<input type="checkbox"/>	Unexplained stomach pain and/or gastrointestinal problems.
<p>Intermediate and progressive effects of exposure to uranium - Please check those symptoms and conditions that apply to you now or have in the past that have an unexplained origin</p>		
24.	<input type="checkbox"/>	Chronic, progressive and repeating symptoms listed in Appendix A
25.	<input type="checkbox"/>	Progressive kidney pain and discomfort
26.	<input type="checkbox"/>	Sexual dysfunction
27.	<input type="checkbox"/>	Miscarriages
28.	<input type="checkbox"/>	Birth defects
29.	<input type="checkbox"/>	Infant children unexplainably ill, weak and lethargic
30.	<input type="checkbox"/>	Defeated immune system
31.	<input type="checkbox"/>	Increasing numbers of family members and community health problems People never seem to get well – progressive and repeating poor health

<p>Section H Part II- Specific diseases and conditions</p>		
<p>Please check any of the medical conditions and diseases that apply to you now or in the past that have an unexplained origin.</p>		
1.	<input type="checkbox"/>	Leukemia, lymphoid.
2.	<input type="checkbox"/>	Leukemia, myeloid.
3.	<input type="checkbox"/>	Leukemia, monocytic.
4.	<input type="checkbox"/>	Leukemia, hairy cell.
5.	<input type="checkbox"/>	Leukemia, other.
6.	<input type="checkbox"/>	Leukemia, unspecified cell type.
7.	<input type="checkbox"/>	Thyroid cancer
8.	<input type="checkbox"/>	Breast cancer.
9.	<input type="checkbox"/>	Lung cancer.

10.	<input type="checkbox"/>	Bone cancer.
11.	<input type="checkbox"/>	Liver cancer, primary.
12.	<input type="checkbox"/>	Skin cancer.
13.	<input type="checkbox"/>	Esophageal cancer.
14.	<input type="checkbox"/>	Stomach cancer.
15.	<input type="checkbox"/>	Colon cancer.
16.	<input type="checkbox"/>	Pancreatic cancer.
17.	<input type="checkbox"/>	Kidney cancer.
18.	<input type="checkbox"/>	Urinary bladder cancer.
19.	<input type="checkbox"/>	Salivary gland cancer.
20.	<input type="checkbox"/>	Multiple myeloma.
21.	<input type="checkbox"/>	Posterior subcapsular cataracts.
22.	<input type="checkbox"/>	Non-malignant thyroid nodular disease
23.	<input type="checkbox"/>	Ovarian cancer
24.	<input type="checkbox"/>	Parathyroid adenoma
25.	<input type="checkbox"/>	Malignant tumors, brain and central nervous system
26.	<input type="checkbox"/>	Lymphomas other than Hodgkin's disease
27.	<input type="checkbox"/>	Cancer, rectum.
28.	<input type="checkbox"/>	Cancer, small intestine.
29.	<input type="checkbox"/>	Cancer, pharynx.
30.	<input type="checkbox"/>	Cancer, bile duct.
31.	<input type="checkbox"/>	Cancer, gall bladder.
32.	<input type="checkbox"/>	Cancer, renal pelvis, ureters, urethra.
33.	<input type="checkbox"/>	Cancer, prostate.
34.	<input type="checkbox"/>	Brochio-alveolar carcinoma.
35.	<input type="checkbox"/>	Benign neoplasm's, brain and central nervous system
36.	<input type="checkbox"/>	Other malignancies not listed
37.	<input type="checkbox"/>	Skin Abnormalities
38.	<input type="checkbox"/>	Blood disorder – specify

39.	<input type="checkbox"/>	Cardiovascular disease – specify
40.	<input type="checkbox"/>	Neurological disease – specify
41.	<input type="checkbox"/>	Respiratory disease – specify
42.	<input type="checkbox"/>	Immunological disease – specify
43.	<input type="checkbox"/>	Genetic abnormality in self, immediate family, family tree – specify

Section J - Family History

Please specify if any family members also have one or more of the health issues you have identified (please identify health issue)

		Health Issue
1.		
2.		
3.		
4.		
5.		

Section K – Questions	
Please ask any questions you have regarding this application.	
1.	

**ALL INFORMATION PERSONAL AND MEDICAL WILL BE KEPT CONFIDENTIAL.
YOU ARE PROTECTED BY THE RULES OF PHYSICIAN-PATIENT CONFIDENTIALITY.**

Section L – Signature	
Signature	
1.	
Date	
2.	

The Port Hope Community Health Concerns Committee thanks you for submitting your Application to the Port Hope Radiobiological Studies Project.

**TO PROTECT
YOUR CONFIDENTIALITY
DO NOT E-MAIL THIS APPLICATION**

Please submit application in writing by hand, post or courier.

Keep a photocopy of the application in a secure location.

Address:

UMRC Study

Port Hope Community Health Concerns Committee

Station Main

P.O. Box 476,

Port Hope, Ontario.

L1A 3Z3