



MINISTRY OF HEALTH
SINGAPORE

VACCINE INJURY FINANCIAL ASSISTANCE PROGRAMME FOR COVID-19 VACCINATION REQUEST FOR MEDICAL INFORMATION

IMPORTANT NOTES TO MEDICAL PRACTITIONER

The Vaccine Injury Financial Assistance Programme for COVID-19 Vaccination (“VIFAP”) provides assistance to eligible Singapore citizens, permanent residents and long-term pass holders who experience serious side effects assessed to be caused by the COVID-19 vaccines received under national programmes. These vaccines are registered under the Health Products Act, and administered in accordance with the relevant recommendations of the Expert Committee on Immunisation in Singapore.

To be eligible for the VIFAP, the Vaccinated Person (as named below) must:

- ✓ Be a Singapore Citizen, Permanent Resident or Long-Term Pass holder;
- ✓ Have received the COVID-19 vaccination under the national programmes¹ in Singapore or under dedicated public health programmes by the Ministry of Health (e.g. Sinovac after mRNA (SAM) Programme);
- ✓ Have experienced a serious side effect(s) that required inpatient hospitalisation, or caused permanent severe disability, or was fatal; and
- ✓ Have a doctor’s assessment that the side effect(s) is related to the COVID-19 vaccination.

As part of the VIFAP application, the applicant will need to request the attending medical practitioner involved in the clinical care and management of the side effect(s) to complete the “Request for Medical Information” form. The attending medical practitioner must be conditionally or fully registered with the Singapore Medical Council. The form will be reviewed by the Ministry of Health (MOH) and its appointed clinical panel, to determine the eligibility for assistance. Supporting documents including investigation results or discharge summary reports may be furnished together with the form.

Medical Practitioners are to fill in the “Request for Medical Information” form at no additional cost to the applicant and return the completed form to the applicant for submission to MOH as part of the application.

By filling in this form, you represent that you had been involved in the clinical management of the side effect(s) experienced by the Vaccinated Person, assessed that the side effect(s) may be related to the COVID-19 vaccination, and that all medical information provided is accurate as of the date of submission.

MOH may contact you directly for further clarifications or information.

For more information, please refer to MOH Circulars 31/2021 and 144/2021.

¹ For the Sinovac-CoronaVac vaccine, this refers to vaccinations received under the national programmes from 23 October 2021 to 30 September 2024.

COVID-19 vaccinations received outside the national programmes are not eligible for the VIFAP.

*Parts and fields marked * are compulsory.*

PART D: DETAILS OF THE VACCINE INJURY EPISODE**(Continue on a separate sheet if necessary)***(1) Initial Presentation Vaccination Site/Primary Care/Emergency Department/SOC**

- *History of presenting complaint*
- *Any relevant physical signs and/or altered vital parameters*
- *Investigations (if ordered)*
- *Provisional assessment/diagnosis*
- *Treatment administered (including IM/IV medications)*
- *Follow-up (discharge, hospitalisation or outpatient clinic appointment)*

(2) Issues and Progress during Hospitalisation [NA if no hospitalisation]

- *Diagnosis and issues*
- *Relevant investigations*
- *Treatment administered (including IM/IV medications)*
- *Surgical procedures (if any)*
- *Specialist(s) assessment (if any)*
- *Clinical condition at discharge, including discharge medications, follow up plans with related SOC, allied health services, rehabilitation appointments, if applicable*

(3) Outpatient Progress [NA if none]

- *Details of outpatient follow-up and assessment (if any)*

(4) Any Potential Permanent Impairment/Disability [NA if none]

- *Nature and severity of the disability/impairment*
- *Assessment of the ADLs affected*
- *Expected duration of impairment*
- *Follow up treatment/rehabilitation required*

PART E: ATTENDING DOCTOR'S CERTIFICATION*

By signing this declaration, I hereby certify that:

1. I have personally examined and treated the Vaccinated Person for the above condition.
2. All answers given represent my medical opinion of his/her condition, and all medical information provided is accurate as of the date of completion of this form.

Name of Attending Doctor and MCR number	Official Email Address	Signature	Date (dd/mm/yyyy)
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