

FORCED STERILIZATIONS CLASS ACTION

COOPER REGEL LLP and KOSKIE MINSKY LLP are commencing a class action that is composed of INDIGENOUS WOMEN who were STERILIZED in Alberta prior to December 14, 2018, WITHOUT their proper and informed CONSENT

Completing this questionnaire allows us to learn of your experiences and circumstances. A lawyer may be in contact with you to discuss the matter further. Your contact information will be added to a database so that we may contact you.

Please return this QUESTIONNAIRE to

Cooper Regel LLP
77 Chippewa Road
Sherwood Park AB
T8A 6J7

info@CooperRegel.ca

1-800-994-7477

Fax: 780-570-8467

What is your full Name: _____

First Name: _____

Middle Name: _____

Last Name: _____

Healthcare #: _____

SIN#: _____

Have you ever used any other names or legally changed your name?
(For example: birth names, adopted names, married names, etc.)

Please list them here: _____

Your current contact information:

Home address: _____

City: _____

Province: _____

Postal Code: _____

Daytime phone: _____

Cellular phone: _____

Email Address: _____

Are you on Facebook: _____

Date of Birth: _____

Place of Birth: _____

Where did you grow up: _____

Are you First Nations/Metis/Inuit (please indicate): _____

Please provide your registration/status/treaty number here: _____

Where did the sterilization take place?

Hospital: _____

City/Town: _____

Province: _____

Doctor who performed the procedure: _____

Other medical professionals: _____

When did the sterilization happen, how old were you: _____

Was anyone else asked for permission, besides yourself, to complete this surgery? (i.e., Parent, spouse): _____

What was the purpose of the surgery as described by your doctor/health care provider:

If so, was there a medical reason provided? (Please explain the reasoning they provided, if any):

Were you given an opportunity to decide for yourself whether you wanted a tubal ligation:

Did you feel forced or coerced? If so, how: _____

Were you sent to a different clinic or hospital outside of your regular obgyn/ general practice doctor: _____

Are you aware of what type of tubal ligation you received? (Cut and tied tubes or cauterized burned): _____

Were you made aware of any opportunity to reverse the tubal ligation you received:

Were you offered advice on other forms of birth control outside of a tubal ligation:

Did you or did you suffer from any other forms of reproductive disease/conditions:

Were there any subsequent physical affects/ responses in your body? (Health issues, scarring, injury, resulting symptoms):

When did you discover that this happened to you: _____

Did you already have children? Were you planning on having others: _____

Do you have any underlying medical conditions? (i.e., Cancer, MS, etc):

Did you suffer any injury to your pelvic region before or after the surgery which is unrelated to the tubal ligation: _____

How many children do you have?

Names	DOB	Place of birth

What impact did the forced sterilization have on your life in terms of the following:

- Physical injuries

- Trust of medical professionals, persons in authority.

- Marriages or common-law relationships

- Relationships with own children

- Anxiety, shame, and guilt

- Self-image, self-esteem, and self-confidence

- Other:

Please list any/all hospitals, clinics you have visited since that you can remember:

Hospital/Clinic	City/Town

PLEASE NOTE: At This Time, **WE ARE NOT RETAINED**, and you are not our client. This Information Is collected for our database for information and contact purposes only.

Dated at _____, _____, this _____ day of _____,
2022.

Signature