

**You should fill in this form in the following situations:**

**To apply for indemnities** when the industrial accident or occupational disease has the following consequences:

- **you are unable to do your job for more than 14 days;**
- **you have a permanent physical or psychological disability;**
- **it results in the death of the worker;**
- **you have a recurrence, relapse or aggravation of your initial injury or disease;**

**To apply for indemnities** when you are not receiving any wages from an employer (you are a volunteer, independent worker, etc.);

**To apply for reimbursement** of medical, travel and living expenses for the first time;

**To apply for reimbursement** of expenses incurred to repair or replace glasses or some other orthosis or prosthesis damaged in the course of your work.

**If you believe that you have an occupational disease, fill out the appendix to the *Worker's Claim* that corresponds to your disease:**

- Appendix to the Worker's Claim – Occupational disease – Hearing impairment;
- Appendix to the Worker's Claim – Occupational lung disease;
- Appendix to the Worker's Claim – Occupational disease – Vibrations.

Other documents may be required for the analysis of your claim. To find out what documents you need depending on your situation, visit our website at [www.cnesst.gouv.qc.ca](http://www.cnesst.gouv.qc.ca).

**The CNESST will process your claim once it has received all the necessary information.**

Please attach any original receipts and vouchers to your claim. If you have a medical certificate, attach it to your claim to accelerate processing.

**Deadline:** In the case of a work accident, you have six months from the date of the accident to submit your *Worker's Claim*. In the case of an occupational disease, the six-month period starts on the day you are made aware that you have an occupational disease or the day on which the worker dies from the disease. However, if you are a beneficiary and you have never filed a claim related to the worker's death, you will lose your right to compensation after seven years following the worker's death. As a result, no claim may be filed after that time.

**Note :** According to the *Act respecting industrial accidents and occupational diseases*, the worker or their representative must give the employer a copy of this form, duly completed and signed.

**This document has three sections:**

1. How to fill in the form
2. "Worker's Claim" form
3. Your protection in case of an industrial accident or an occupational disease

Send the completed document to Commission des normes, de l'équité, de la santé et de la sécurité du travail :

<b>Online</b> <a href="http://cnesst.gouv.qc.ca">cnesst.gouv.qc.ca</a>	<b>By mail</b> CNESST, C. P. 2026, Succ Terminus Québec (Québec) G1K 0H9	<b>By fax</b> 1 855 722-8081	<b>Just one number for the CNESST</b> 1 844 838-0808
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# How to fill in the form

If you need help filling in this form, contact the CNESST at 1 855 722-8081.

In this form, the word “**event**” is used to describe both an industrial accident and the appearance of an occupational disease.

The term “**employment injury**” refers to a work-related accident, occupational disease, or a recurrence, relapse or aggravation of a previous employment injury.

1 • Identification of the worker			
Surname (as shown on birth certificate)		Health insurance no. <input type="text"/>	
First name		Social insurance no. <input type="text"/>	
Home address      Number   Street   Apt.		Date of event <input checked="" type="checkbox"/> <input type="text"/>	
City		Date of recurrence, relapse or aggravation <input type="text"/> <input checked="" type="checkbox"/>	
Province, Country		Date of birth <input type="text"/>	
Telephone	Telephone (other)	Sex F <input type="checkbox"/> M <input type="checkbox"/>	Check if you are any of the following <input type="checkbox"/> volunteer <input type="checkbox"/> owner, partner, executive officer, member of the Board of Directors, independent worker, domestic worker

### Date of event

Date of the industrial accident or the date you knew you had an occupational disease.

### Date of recurrence, relapse or aggravation

Date of deterioration of your health related to a prior employment injury. Indicate the exact date as well as the date of the original event to which it is related.

2 • Identification of the employer		À l'usage de la CNESST	
Employer's name (business name)		N° de dossier d'expérience      EXP <input type="text"/>	
Address of the establishment to which the worker is attached      Number   Street   Suite		Contact person <input type="text"/>	
City		Telephone <input type="text"/>	Extension <input type="text"/>
Province, Country		Fax <input type="text"/>	

Identify the employer you were working for at the time of the accident or the appearance of the occupational disease.

Give the address of your usual place of work.

If you know the name of the person who handles work-related accident and illness claims for your employer, write it here.

3 • Place of event	
<input checked="" type="checkbox"/> In Québec	<input checked="" type="checkbox"/> Workstation <input checked="" type="checkbox"/> Elsewhere in the establishment (parking lot, cafeteria, etc.) <input checked="" type="checkbox"/> Outside the workplace (on the road, visiting a client, etc.)
<input type="checkbox"/> Outside Québec, indicate the province or country, if outside Canada	<input type="text"/>

First indicate if the event occurred in Québec or outside Québec by checking the appropriate box.

If the event occurred in Québec, specify by checking one of the three boxes.

If the event occurred outside Québec but in Canada, write the name of the province on this line. If the event occurred outside Canada, write the name of the country.

If the event occurred at sea (on a boat) or in the air (on an airplane) also indicate that on this line or give more details in section 4 - Description of the event.

#### 4 • Description of the event

Describe the circumstances of the employment injury

**EXAMPLE: ACCIDENT**

While slicing a piece of beef, I slashed my left hand deeply.

**EXAMPLE: OCCUPATIONAL DISEASE**

I have been having pain in my left elbow for six months. The pain wasn't preventing me from working, but in the past week it increased and I had to stop working. My doctor diagnosed tendonitis caused by repetitive movements in my work.

**EXAMPLE: RECURRENCE, RELAPSE, AGGRAVATION**

Two months ago I had an industrial accident in which I sprained my right knee. I was on sick leave for two weeks. Since I returned to work, the pain has increased. This morning I saw my doctor who told me to stop working.

Occupation or trade carried on at the time of the event

Indicate how the injury occurred and describe what you were doing at the time of the event: for example, what tasks you were engaged in, the equipment you were using, your movements and motions, etc. Specify the injuries by indicating the parts of your body that were affected.

If necessary, add a detailed description of the facts and all other relevant information to help us analyze your claim.

#### 5 • Work stoppage

**Work stoppage**

Yes  No

Date of last day worked

Y Y Y Y M M D D

**Return to work**

Yes  No

Date of return

Y Y Y Y M M D D

- Same job
- Temporary work assignment
- Other

Date of last day worked (full or partial). The date should correspond to the day you left work.

Check "Same job" only if you returned to the job you held before the accident and under the same conditions. In other words, if you have the same duties and the same work schedule as before the accident.

Check the "Temporary work assignment" box if your employer has assigned you, with your health professional's agreement, to safe and productive tasks until you are able to do your job again.

#### 6 • Information required for the calculation and payment of income replacement indemnities

**Family situation and number of dependants declared for income tax purposes**

- Single
- With dependent spouse
- With non-dependent spouse
- Single parent family

Number of **minor** dependants

Number of **adult** dependants (including spouse)

Annual income \$ \_\_\_\_\_  
Explain: \_\_\_\_\_

**Other employment**

- Do you have more than one job?  Yes  No
- Does your injury prevent you from working at your other jobs?  Yes  No

Is your employer still paying you after the first 14 days of inability to work?  Yes  No

In order to determine your compensation, we need to know your family situation declared according to income tax legislation. Check the box that corresponds to your family situation at the time of your employment injury.

From the 15th day of work stoppage, the CNESST will pay the income replacement indemnity. If your employer continues to pay you, check the appropriate box.

Enter the number of your dependants. **A dependant is a person for whom, at the time of the event, you are entitled to claim any of the following:**

- at the minimum, a full or partial tax credit; or
- an income deduction; or
- a deduction for supporting that person.

If your spouse is your dependant, include them in the number of adult dependants.

## 6 • Information required for the calculation and payment of income replacement indemnities

<b>Family situation and number of dependants declared for income tax purposes</b> <input type="checkbox"/> Single <input type="checkbox"/> With dependent spouse <input type="checkbox"/> With non-dependent spouse <input type="checkbox"/> Single parent family		Number of <b>minor</b> dependants <input type="text"/> Number of <b>adult</b> dependants (including spouse) <input type="text"/>	Annual income \$ <input type="text"/> Explain: <input type="text"/> <b>Other employment</b> Do you have more than one job? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Does your injury prevent you from working at your other jobs? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is your employer still paying you after the first 14 days of inability to work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

The CNESST uses the **annual income** stated in your **employment contract** to determine your income replacement indemnity. Usually, the annual income consists of gross wages that would have been paid for normal job performance in any given year.

E.g., \$15/hour X 40 hours X 52.14 weeks = \$31,284

If you are an individual registered with the CNESST, indicate the amount of your personal coverage.

If, during the 12 months preceding the event, your income was higher than the amount stipulated in your **employment contract**, indicate the amount earned in the space provided.

You can include the following amounts in your annual income:

- bonuses, premiums, gratuities, commissions
- overtime pay
- vacation pay if not included in your annual income
- profit-sharing
- cash value of personal use of a car or dwelling provided by the employer
- parental leave benefits
- employment insurance benefits

Indicate if you had more than one job at the time of the event, regardless of whether or not your injury prevents you from working at them. The rules for determining your income may be applied differently in that case.

## 7 • Claim for orthosis or prosthesis damaged in the course of work

I certify that such expenses are not reimbursed by any of the employer's insurance plans.	Employer's signature <input type="text"/>	Y Y Y Y M M D D
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Upon submission of supporting documentation, you are entitled to compensation for repairing or replacing a prosthesis or orthosis damaged inadvertently during a sudden and unforeseen event in the course of work, provided that you are not entitled to such compensation under some other plan.

You must ask your employer to sign an attestation that the enterprise has no insurance plan covering such expenses.

## 8 • Declaration and authorization

I declare that the information provided in this claim is true and complete. Anyone who makes a false statement is guilty of an offence and is subject to a fine.	Signature of the worker or their representative <input type="text"/>	Y Y Y Y M M D D
Pursuant to section 270 of the <i>Act respecting industrial accidents and occupational diseases</i> , the worker or their representative must give the employer a copy of this document duly completed and signed.		
If the event caused death, identify the person to contact and the date of death.	Person to contact (spouse, liquidator, etc.) <input type="text"/>	Telephone <input type="text"/>
		Date of death <input type="text"/>

It is important to sign and date the form.

## 9 • Authorization to disclose and collect information

I authorize any physician or health professional, health worker, healthcare or social services institution or clinic to release information concerning my state of health to the CNESST for the purposes of processing my claim. I authorize the CNESST to disclose the necessary information contained in my file in connection with the processing of my claim to any rehabilitation provider with whom the CNESST does business in order to obtain rehabilitation services. Subject to express revocation in writing by me, these authorizations remain valid until this claim has been fully processed.	Signature of the worker <input type="text"/>	Y Y Y Y M M D D
Certain information concerning the worker may be sent to other government agencies that have signed agreements with the CNESST respecting the exchange of information pursuant to the <i>Act respecting access to documents held by public bodies and the protection of personal information</i> .		

While your claim is being processed, we may require information regarding your state of health to determine your entitlement to benefits. We need your authorization so that the CNESST can obtain that information from your health professional, healthcare institution, health worker or clinic.

In addition, you may also need rehabilitation services. We must obtain your consent to release certain documents contained in your file to rehabilitation providers, such as occupational therapists, employment counsellors, accommodation consultants, etc., who may be involved in your case.

**À l'usage de la CNESST**

N° de dossier du travailleur

Poste de travail

**1 • Identification of the worker**

Surname (as shown on birth certificate)		Health insurance no.	<input type="text"/>
First name		Social insurance no.	<input type="text"/>
Home address	Number Street Apt.	Date of event	<input type="text"/>
City		Date of recurrence, relapse or aggravation	<input type="text"/>
Province, Country	Postal code <input type="text"/>	Date of birth	<input type="text"/>
Telephone	Telephone (other)	Sex	F <input type="checkbox"/> M <input type="checkbox"/>
		Check if you are any of the following <input type="checkbox"/> volunteer <input type="checkbox"/> owner, partner, executive officer, member of the Board of Directors, independent worker, domestic worker	

**2 • Identification of the employer**

Employer's name (business name)		<b>À l'usage de la CNESST</b>	
Address of the establishment to which the worker is attached		N° de dossier d'expérience	EXP <input type="text"/>
City		Contact person <input type="text"/>	
Province, Country		Telephone	Extension <input type="text"/>
Postal code <input type="text"/>		Fax <input type="text"/>	

**3 • Place of event**

In Québec →  Workstation  Elsewhere in the establishment (parking lot, cafeteria, etc.)  Outside the workplace (on the road, visiting a client, etc.)

Outside Québec, indicate the province or country, if outside Canada

**4 • Description of the event**

Describe the circumstances of the employment injury

Occupation or trade carried on at the time of the event

**5 • Work stoppage**

<b>Work stoppage</b>	Date of last day worked	<b>Return to work</b>	Date of return	<input type="checkbox"/> Same job
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Temporary work assignment
				<input type="checkbox"/> Other

**6 • Information required for the calculation and payment of income replacement indemnities**

<b>Family situation and number of dependants declared for income tax purposes</b>		Annual income \$ <input type="text"/>
<input type="checkbox"/> Single	Number of minor dependants <input type="text"/>	Explain: <input type="text"/>
<input type="checkbox"/> With dependent spouse	Number of adult dependants (including spouse) <input type="text"/>	<b>Other employment</b>
<input type="checkbox"/> With non-dependent spouse		Do you have more than one job? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Single parent family		Does your injury prevent you from working at your other jobs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is your employer still paying you after the first 14 days of inability to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**7 • Claim for orthosis or prosthesis damaged in the course of work**

I certify that such expenses are not reimbursed by any of the employer's insurance plans.  Employer's signature

**8 • Declaration and authorization**

I declare that the information provided in this claim is true and complete.  Signature of the worker or their representative

Pursuant to section 270 of the Act respecting industrial accidents and occupational diseases, the worker or their representative must give the employer a copy of this document duly completed and signed.

If the event caused death, identify the person to contact and the date of death.	Person to contact (spouse, liquidator, etc.) <input type="text"/>	Telephone <input type="text"/>	Date of death <input type="text"/>
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**9 • Authorizations to communicate and collect information**

I authorize any physician or health professional, health worker, healthcare or social services institution or clinic to release information concerning my state of health to the CNESST for the purposes of processing my claim.

I authorize the CNESST to disclose the necessary information contained in my file in connection with the processing of my claim to any rehabilitation provider with whom the CNESST does business in order to obtain rehabilitation services.

Subject to express revocation in writing by me, these authorizations remain valid until this claim has been fully processed.

Signature of the worker

Certain information concerning the worker may be sent to other government agencies that have signed agreements with the CNESST respecting the exchange of information pursuant to the Act respecting access to documents held by public bodies and the protection of personal information.

## Your protection in case of an industrial accident or an occupational disease

Should you have an industrial accident or contract an occupational disease, the *Act respecting industrial accidents and occupational diseases* protects you. It guarantees you the right to medical aid and, if your condition requires it, the right to compensation, rehabilitation and return to work. The CNESST administers the services provided for under the Act and ensures that you will be able to exercise your rights under that law.

Therefore, when you work for an employer, you are insured in case of an industrial accident or an occupational disease. You pay nothing for this insurance: all costs are covered by the annual assessments that your employer and other employers in Québec pay to the CNESST.

## The right to medical aid

As soon as you are injured in an industrial accident or an occupational disease becomes apparent, you may be entitled to all the medical care, treatment and services required as a result of your employment injury, as prescribed by the *Act respecting industrial accidents and occupational diseases*. The CNESST bears the costs of such expenses.

You choose your health professional and the hospital where you will be treated.

If your health professional prescribes any of the following medical care, treatment or services in connection with your employment injury, the CNESST will pay for them:

- services provided by physicians, dentists, pharmacists and optometrists;
- services dispensed in public healthcare institutions;
- medication and other pharmaceutical products;
- orthoses, prostheses and technical aids;
- the following care and treatment dispensed privately: acupuncture, audiology, chiropractic treatments, occupational therapy, speech therapy, physiotherapy, podiatry, psychotherapy and certain home care services.

Various conditions apply if the employment injury occurs in border areas or outside Québec. For more information, call 1 844 838-0808. However, the CNESST will not reimburse any amount to a worker whose injury occurred in Québec but whose personal decision was to be treated outside of Québec.

To be compensated for your medical aid expenses, you must submit a request for reimbursement. You may use the form entitled “*Application for Reimbursement of Expenses*” and submit it with vouchers. The form is available at any regional CNESST office, and on the CNESST website ([cnesst.gouv.qc.ca](http://cnesst.gouv.qc.ca)).

**You should keep all originals of your receipts in order to be reimbursed.**

## The right to compensation

### Loss of income

If, as a result of an industrial accident or an occupational disease, you are unable to do your job, you may be entitled to an indemnity for lost salary or wages. When applicable, you could continue to be paid an indemnity throughout the rehabilitation period, until you can resume your work or, if that goal cannot be achieved, until you can hold other suitable employment.

Your employer must pay you 100% of your net wages for that part of the day that you become unable to work because of your injury.

Then, for the next 14 days, upon presentation of a medical certificate confirming that you are unable to do your job, your employer must pay you 90% of your net salary up to the maximum insurable earnings prescribed under the Act, for each day that you would have worked had it not been for your injury. If, during this same period, you lose other employment income and can demonstrate this to the CNESST, your indemnity may be increased.

If no employer was obliged to pay you wages at the time your employment injury occurred, you will be entitled to an income replacement indemnity subject to certain conditions.

As of the 15th full day following the beginning of your disability, you may be entitled to an income replacement indemnity payable every two weeks. The indemnity corresponds to 90% of your annual net income from your employment, up to the maximum insurable earnings prescribed under the Act, taking into account your family situation declared for income tax purposes.

### Bodily injury

You may suffer permanent physical or mental impairment as a result of an industrial accident or an occupational disease. In such a case, the CNESST will pay you a lump sum. The amount of the lump sum will be determined according to a scale that takes into account your physical or mental impairment, any disfigurement, pain and suffering or resulting loss of enjoyment, as well as your age.

### Death of a worker

When a worker dies as a result of an industrial accident or an occupational disease, the spouse and dependants may receive compensation from the CNESST, usually in the form of a lump sum or a pension.

### Other indemnities

Upon submission of supporting documentation, the CNESST will reimburse you, and the person who must accompany you as a result of your physical condition, for travel and accommodation expenses incurred to receive treatment, undergo medical exams or perform an activity that is part of your personalized rehabilitation plan, in accordance with the standards and for the amounts determined by the *Regulation respecting travel and living expenses*. Your application for reimbursement must be submitted no later than six months after the date you incurred the expenses.

You are also entitled to compensation, upon submission of supporting documentation, up to the maximum prescribed under the Act, subject to the applicable deduction, for the following expenses:

- cleaning, repair or replacement of clothing damaged as a result of an industrial accident;
- cleaning, repair or replacement of clothing damaged by an orthosis or prosthesis that you are required to wear as a result of an employment injury;
- repair or replacement of an orthosis or prosthesis damaged inadvertently during a sudden and unforeseen event in the course of work, provided that you are not entitled to such compensation under some other plan.

## Rehabilitation Measures and the Right to Rehabilitation

The CNESST can grant you rehabilitation measures as soon as your employment injury is accepted. Rehabilitation measures granted before the consolidation of your injury are aimed at your professional reintegration, and other rehabilitation measures may be provided when they are required due to your state of health.

If, as a result of an employment injury, your physical or psychological integrity is permanently impaired, you are entitled to the rehabilitation that your condition requires for your social and professional reintegration.

To benefit from the right to rehabilitation, you must meet the eligibility criteria for rehabilitation.

In this case, the CNESST prepares and implements, with your collaboration and that of your employer, if applicable, an individualized rehabilitation plan which may include a social and occupational rehabilitation program.

## The right to return to work

As soon as you become capable of performing your job following an employment injury, you have the right to return to your job in the establishment where you were working at the time of the injury, or if it no longer exists, to an equivalent job in the establishment where you work or in another establishment of your employer.

You are entitled to retain your seniority and receive the salary and benefits you would have received if you had continued in your job

You can exercise your right to return to work up to one year after you became disabled from your job if the establishment in which you were employed had 20 or fewer workers at that time. This period is two years if the establishment had 21 or more workers.

You may also exercise your right to return to work before the expiry of the time limit set out in your collective agreement, if that time limit is longer than the ones mentioned above. When your time limit for exercising your right to return to work has not expired, your employer is deemed to be able to reinstate you in accordance with a decision of the CNESST that establishes your ability to perform your job, an equivalent job, or a suitable job available with your employer. However, the return-to-work period must not prevent you from being reinstated with your employer. If your return-to-work period has expired, your employer is presumed to be able to reinstate you, unless it demonstrates that reinstatement would impose an undue hardship

The right to return to work applies to a worker who, on the date of his or her work injury or occupational disease, is under a contract of employment for an indefinite period, or for a definite period if he or she becomes capable of performing his or her job before the expiry date of his or her contract.

If you remain unable to perform your job because of your employment injury, you are entitled to the first suitable job that becomes available in your employer's establishment, subject to the seniority rules in your collective agreement.

Until you are able to do your job or a suitable job again, your employer may temporarily assign you to a job if your health care professional determines that you are able to do the job, that it does not affect your health and safety, and that it is beneficial to your rehabilitation.

## Recourse

You may apply for a review of the decisions rendered by the CNESST. You must apply in writing within the time limit prescribed under the Act. You can also contest the decision rendered in the review process before the Tribunal administratif du travail.

If you believe that you have been the subject of a sanction or reprisals by your employer or that you have been discriminated against by your employer because of your employment injury or because you exercised a right under the *Act respecting occupational health and safety* and the *Act respecting industrial accidents and occupational diseases*, you may use the grievance procedure provided for in your collective agreement or file a complaint with the CNESST.

**For further information, contact the CNESST  
at 1 844 838-0808.**

### **To benefit from the protection provided by law, you must fulfill certain obligations.**

- Notify your employer or your employer's representative of your industrial accident or occupational disease as soon as possible, preferably before leaving the establishment.
- Provide your employer with a medical certificate if you are unable to resume work after the day of the accident.
- File a claim with the CNESST on the attached form if your inability to work lasts longer than 14 days.
- Supply all the information required by the CNESST.
- Undergo the medical examinations required by your employer or the CNESST to the extent provided for by law.
- Follow the medical treatments that your health professional considers necessary.
- Inform your employer and the CNESST promptly of any change in your situation that may affect the amount of your income replacement indemnity.
- Inform your employer of the date of your return to work and whether or not you have a permanent impairment.
- Return to work as soon as you are able.