Information

Application for Disability Benefits Under the Québec Pension Plan

Information

Disability benefits

If you are under age 65, have sufficiently contributed to the Québec Pension Plan and are disabled, you could be entitled to disability benefits under the Plan. There are two pensions:

- the disability pension;
- the pension for a disabled person's child.

Retraite Québec can deem you to be disabled if your disability is **severe** and if it prevents you from doing any type of work on a full-time basis. In addition, your disability must be **permanent**, which means it is of **indefinite duration** with no possibility of improvement.

However, if you are between ages 60 and 65 and your state of health prevents you from doing the usual work you left when you became disabled, you could be entitled to a disability pension. You will have to prove that you recently worked, that is, that you contributed to the Plan for at least four of the last six years in your contributory period. The contributory period ends in the year in which we deem a person to be disabled.

If you are under 65 years of age, a beneficiary of a retirement pension under the Québec Pension Plan and we can no longer cancel your retirement pension, you could receive an additional amount for disability if you are unable to do any type of work on a full-time basis. Note that you must show that you recently worked.

Important: You must notify us if you return to work while your application for disability benefits is being studied.

Disability pension or additional amount for disability

A disability pension or an additional amount for disability is:

- payable as of the fourth month following the one in which we consider a person to be disabled. Thus, a person who is deemed to be disabled as of January receives a first pension payment in May. The last payment is made in the month of the person's 65th birthday. The disability pension is automatically replaced by a retirement pension at that time;
- indexed each year in January, according to the cost of living;
- taxable.

Pension for a disabled person's child

If you are granted a disability pension, your children could be entitled to a pension for a disabled person's child until age 18, **if an application is filed**.[1] They are eligible for the pension if they:

- are your biological or adopted children; or
- have been living with you for at least one year and you serve as mother or father to them.

  Children are not eligible for this pension if they were placed in your home in foster care and you are receiving amounts for them.

The pension for a disabled person's child is paid on a priority basis to the disabled person who provides for the children's needs. Otherwise, the pension is paid to the person responsible for the children. Regardless of who is receiving the pension for a disabled person's child, it does not reduce the amount of the disability pension.

The pension for a disabled person's child is paid monthly. Payment ends when the child turns 18 or the disability pension stops being paid. The person receiving the pension must notify us if he or she is no longer responsible for the children.

Impact on other benefits

If you are already receiving a surviving spouse's pension under the Québec Pension Plan, that pension could be reduced once a disability pension becomes payable. Please note that you cannot receive disability benefits under the Plan if you are already receiving disability benefits under the Canada Pension Plan.

Our criteria for determining if a person is disabled are not the same as those of the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST), the Société de l'assurance automobile du Québec (SAAQ) or the Ministère du Travail, de l'Emploi et de la Solidarité sociale. The criteria used by insurance companies may also differ from those of Retraite Québec.

If you receive or expect to receive benefits from other public or private sources, you should find out from those other sources whether or not receiving disability benefits under the Québec Pension Plan would cause such benefits to be reduced.

[1] Children for whom an orphan's pension or a pension for a disabled person's child is already being paid under the Québec Pension Plan or the Canada Pension Plan are not entitled to a second pension.

A pension for a disabled person's child is not payable where a beneficiary of a retirement pension is receiving an additional amount for disability.

How to apply

Fill out the form and return it to us immediately. Do not wait for the Medical Report. The date we receive your application may affect the date you begin receiving your benefits, since the maximum retroactivity possible is 12 months from the date we receive the application, even if you were disabled before that time.

You must have the Medical Report completed by your physician. Be sure to ask him or her to send it back to us as soon as possible. Your physician may charge you a fee for filling out the Medical Report. You are responsible for paying that fee.

Work outside Canada

If you participated in a social security plan in another country, you could be entitled to a pension under that plan. Benefits paid under the Québec Pension Plan are not reduced if you are receiving a pension from another country.

Instructions – Application for Disability Benefits Under the Québec Pension Plan

1. Answer all the questions on the Application for Disability Benefits Under the Québec Pension Plan and sign it.
2. Fill out and sign the **Consent Regarding the Release of Medical, Psychosocial and Administrative Information**.
3. Include a copy of all medical reports and test results that you have in your possession that concern your disability. **(Do not send X-ray films.)**
4. Be sure to use sufficient postage, and mail it to the following address as soon as possible:

   Retraite Québec, case postale 5200
   Québec (Québec) G1K 7S9

Instructions – Medical Report form

1. You (the applicant) must fill out section 1 of the Medical Report, Information about the applicant's identity.
2. Have the other sections completed by your physician. He or she will send the report directly to us.

Access to documents held by public bodies and the protection of personal information

The information requested on this form is needed in order for us to study your application. Failure to provide the information may result in delays in processing the application or in the application being rejected. Only authorized employees at Retraite Québec will have access to the information. The information can be provided to other persons or agencies or verified with them only in the cases provided for by law. It could also be used for research, assessments, enquiries or surveys. Under the *Act respecting Access to documents held by public bodies and the Protection of personal information*, you may consult the information and have your personal information corrected.

Time required to render a decision

In our *Service Statement*, we are committed to replying to an application for disability benefits within 150 days, if the information received initially is sufficient to render a decision. The time period begins once we have received your application and the Medical Report.

In addition, to check the status of your application, consult the My Account online service at any time.

Main steps in processing your application

When processing your application for disability benefits, we will carry out the following steps:

- When your application is received, it will be studied. Your application will be checked against administrative criteria in order to determine your eligibility for benefits under the Québec Pension Plan (the number of years you contributed to the Plan, the date you stopped working, etc.). Any missing information will be obtained, as required.

If you are eligible from an administrative standpoint, your application moves on to the next steps:

- Your file will be sent to our medical team.
- The medical information in your application and the Medical Report will be verified. In order to complete your medical file, additional medical information may be obtained, as required, from your attending physician, medical specialists, hospitals, insurance companies or government agencies with which you have been in contact.
- One of our medical advisors will review your medical file to determine whether you can be deemed to be disabled under the *Act respecting the Québec Pension Plan*. Under certain circumstances, you may be asked to undergo a medical examination.
- We will render a decision with regard to your application.

For more information

Online
My Account

Access your file **24/7**

www.retraitequebec.gouv.qc.ca

By telephone
Québec region: 418 643-5185
Montréal region: 514 873-2433
Toll-free: 1 800 463-5185

0100002 LE

Retraite Québec

Application for Disability Benefits Under the Québec Pension Plan

Important: You must provide your social insurance number where requested to avoid delays in processing your application.

If you need more space, use a separate sheet. Be sure to indicate your social insurance number on it and indicate the number of the question to which the information pertains.

Please complete the form and return it to:
Retraite Québec, case postale 5200, Québec (Québec) G1K 7S9

Indicate your social insurance number

1. Identification

Sex ☐ F ☐ M	Family name	Given name
	Family name at birth, if different	Given name at birth, if different

Date of birth (year / month / day)	Place of birth (city, province, country)

Your mother's family name at birth	Your mother's given name
Your father's family name	Your father's given name

Language of correspondence ☐ French ☐ English

Your address (number, street, apt.)

City	Province	Country	Postal code

Telephone
Home (area code) Other (area code) Extension

If you live outside Canada, what was your last province of residence in Canada?

2. Participation in other plans

Have you ever participated in the social security plan of another country? ☐ Yes ☐ No

If so, in which country or countries? _____

Please indicate your foreign social insurance numbers. _____

Indicate your social insurance number

3. Information about your children

Certain situations could help you become eligible for benefits or increase the amount:

- if you received family benefits for any children (Québec child assistance, Québec family allowance or Canada Child Tax Benefit);
- if you were entitled to family benefits but did not receive any because your family income was too high.

3.1 Throughout your lifetime, did you **have children, adopt or become responsible for** any children (regardless of their current age)?

☐ Yes ☐ No. Go to **section 4**.

3.2 Did you receive family benefits paid **in your name** for any children **OR**, if you did not, was it because your family income was too high? (Benefits are usually paid to the mother.)

☐ Yes. Complete the following. ☐ No. Go to **section 4**.

Information about your children			
1st child			
Family name at birth	Given name	Date of birth (year, month, day)	
Place of birth (province, country)	Date of adoption or date child became your dependent (if applicable) (year, month)	Date of death (if child died before age 7) (year, month)	
Child born outside Canada: Date of arrival in Canada (year, month)	Province of residence at time of arrival in Canada		
2nd child			
Family name at birth	Given name	Date of birth (year, month, day)	
Place of birth (province, country)	Date of adoption or date child became your dependent (if applicable) (year, month)	Date of death (if child died before age 7) (year, month)	
Child born outside Canada: Date of arrival in Canada (year, month)	Province of residence at time of arrival in Canada		
3rd child			
Family name at birth	Given name	Date of birth (year, month, day)	
Place of birth (province, country)	Date of adoption or date child became your dependent (if applicable) (year, month)	Date of death (if child died before age 7) (year, month)	
Child born outside Canada: Date of arrival in Canada (year, month)	Province of residence at time of arrival in Canada		
4th child			
Family name at birth	Given name	Date of birth (year, month, day)	
Place of birth (province, country)	Date of adoption or date child became your dependent (if applicable) (year, month)	Date of death (if child died before age 7) (year, month)	
Child born outside Canada: Date of arrival in Canada (year, month)	Province of residence at time of arrival in Canada		
If there are more than four children, provide the additional information on a separate sheet.			

3.3 Between the birth and the 7th birthday of each of these children, were there any periods during which family benefits were **not paid in your name**? ☐ Yes ☐ No

3.4 Between each child's birth or arrival in Canada and that child's 7th birthday, did each of these children **always live with you in Canada**? ☐ Yes ☐ No

4. Benefits from other agencies

4.1 Have you ever applied for an indemnity from the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) following a work-related accident or an occupational disease (whether or not it was related to your current disability)? ☐ Yes ☐ No

If so, in what year? ____ Give your CNESST file number. ____

For what reason? ____

What is the current status of your file at the CNESST?

☐ I have not yet received an answer from the CNESST.
☐ I am **currently** receiving an indemnity from the CNESST.
☐ I was receiving an indemnity from the CNESST but have stopped receiving it.
☐ The CNESST rejected my application.

Did the CNESST ask for an **expert medical opinion**?[1] ☐ Yes ☐ No

4.2 Have you ever applied for an indemnity from the Société de l'assurance automobile du Québec (SAAQ) following an automobile accident (whether or not it was related to your current disability)? ☐ Yes ☐ No

If so, in what year did the accident occur? ____ Give your SAAQ file number. ____

What is the current status of your file at the SAAQ?

☐ I have not yet received an answer from the SAAQ.
☐ I am **currently** receiving an indemnity from the SAAQ.
☐ I have received an indemnity from the SAAQ **in the last 12 months** but have stopped receiving it.
☐ I was receiving an indemnity from the SAAQ but stopped receiving it more than 12 months ago.
☐ The SAAQ is currently reviewing my application.
☐ The SAAQ rejected my application.

Did the SAAQ ask for an **expert medical opinion**?[1] ☐ Yes ☐ No

4.3 Have you ever applied for benefits from an insurance company because of your disability? ☐ Yes ☐ No

If so, indicate the company's name. ____ Give your file number. ____

Did the insurance company ask for an **expert medical opinion**?[1] ☐ Yes ☐ No

[1] By "expert medical opinion," we mean an appointment with a physician or a health care professional at the request of a third party (e.g. CNESST, SAAQ, insurance company, employer or other). Unlike the attending physician, the physician or health care professional does not treat the person he or she is asked to examine.

5. Education and training

5.1 What level of education did you complete? ☐ Elementary ☐ Secondary ☐ College ☐ University

What is the last diploma you received? ____

5.2 Please list any other training and development (including workplace training, special interest classes, etc.).

____

____

5.3 Do you have a driver's license in good standing? ☐ Yes ☐ No

If so, indicate the class or classes: ____

If there are any restrictions indicated on your license, please list them. ____

____

Indicate your social insurance number

6. Work situation

6.1 **Date you started** your current job **or** your last job (year / month / day)

6.2 Have you **completely** stopped working? ☐ Yes ☐ No

If so, what is the date of the **last day you went to work?** (year / month / day)

If not, how many hours a week do you work? (Hours) What is your gross weekly salary? $

Note: If you return to work or your work hours increase before we have finished studying your application for disability benefits, please notify us.

6.3 Why did you totally or partially stop working?

6.4 What is or was your job?

Briefly describe your work.

Name of your last employer:

Telephone (area code) Extension

6.5 Do you have another job? ☐ Yes ☐ No

If so, how many hours a week do you work? (Hours) What is your gross weekly salary? $

Employer's name:

Telephone (area code) Extension

6.6 Are you currently self-employed? ☐ Yes ☐ No

6.7 Do you own a business? ☐ Yes ☐ No

If so, indicate its name:

Are you still involved in any way in the business's activities? ☐ Yes ☐ No

If so, what are your duties?

6.8 Have you ever been self-employed **or** owned a business? ☐ Yes ☐ No

If so, please give the date the business was sold, dissolved or closed. (year / month / day)

6.9 Have you ever been or are you responsible for a family-type or intermediate resource (foster home or family)? ☐ Yes ☐ No

If so, did or do you take in nine or fewer users at your principal place of residence? ☐ Yes ☐ No

7. Work history

List the other jobs you held before the job described in section 6.

Employer	Type of work	Duration From (year / month)	Duration To (year / month)	Reason for leaving

If there is not enough space, provide the additional information on a separate sheet.

8. Information on your state of health

8.1 Since when have you been unable to work on a regular basis because of your state of health? year month day

8.2 List the illnesses or impairments that prevent you from working or limit you in your work. If you do not know the exact medical terms, describe the problem in your own words.

8.3 List all the medications that you are currently taking.

Name of the medication	The dose you take	How often you take it

8.4 Indicate any other treatment (physiotherapy, psychotherapy, etc.) that you are currently receiving and the place where you are treated.

Treatment	Place

8.5 Indicate, if possible, any special tests you have had during the past six months that are related to the health problem causing your disability (x-rays, treadmill exercise, magnetic resonance imaging, respiratory test, etc.).

Type of test	Hospital or clinic where the test was done

8.6 Can you get around without aid? ☐ Yes ☐ No

If you answered no, which of the following do you use?

☐ Cane ☐ Crutches ☐ Wheelchair Other: _____

9. Information about your physicians

Name the physicians currently caring for you and any physicians you have seen because of your disability. Also indicate the type and name of the institution at which you consulted the physician.

1st physician

Physician's name		Telephone (area code)
☐ Family physician ☐ Specialist	In the case of a specialist, please indicate in which field.	
Type of establishment ☐ Hospital ☐ CLSC ☐ Clinic	Name of establishment	Date you last saw that physician (year / month / day)

2nd physician

Physician's name		Telephone (area code)
☐ Family physician ☐ Specialist	In the case of a specialist, please indicate in which field.	
Type of establishment ☐ Hospital ☐ CLSC ☐ Clinic	Name of establishment	Date you last saw that physician (year / month / day)

3rd physician

Physician's name		Telephone (area code)
☐ Family physician ☐ Specialist	In the case of a specialist, please indicate in which field.	
Type of establishment ☐ Hospital ☐ CLSC ☐ Clinic	Name of establishment	Date you last saw that physician (year / month / day)

If there is not enough space, provide the additional information on a separate sheet.

10. Information on hospital stays

Have you been hospitalized in the last five years? ☐ Yes. Give the following information. ☐ No

1st hospitalization

Approximate date (year / month)	Reason
Name of the hospital	Location

2nd hospitalization

Approximate date (year / month)	Reason
Name of the hospital	Location

3rd hospitalization

Approximate date (year / month)	Reason
Name of the hospital	Location

Indicate your social insurance number

11. Application for a pension for a disabled person's child

For information on the eligibility requirements, refer to the accompanying information sheet.

11.1 Complete the following for each child for whom you wish to apply for a pension for a disabled person's child. Be sure to indicate the **child's social insurance number**, if any.

1st child

Sex ☐ F ☐ M

Family name at birth

Given name

Social insurance number

Date of birth (year / month / day)

Place of birth (city, province, country)

If the child was born outside Québec, provide proof of birth issued by an officer of civil status from his or her place of birth.

His or her mother's given and family names at birth

His or her father's given and family names

Child's address

Same as the disabled person's address ☐

Other address: _____

Is this child your **biological or adopted child**? ☐ Yes ☐ No

If so, for an adopted child, indicate the date of adoption. (year / month / day)

If not, please indicate when the child **began** living with you, if applicable. (year / month / day)

If the child **does not** live with you, please specify the reason. _____

2nd child

Sex ☐ F ☐ M

Family name at birth

Given name

Social insurance number

Date of birth (year / month / day)

Place of birth (city, province, country)

If the child was born outside Québec, provide proof of birth issued by an officer of civil status from his or her place of birth.

His or her mother's given and family names at birth

His or her father's given and family names

Child's address

Same as the disabled person's address ☐

Other address: _____

Is this child your **biological or adopted child**? ☐ Yes ☐ No

If so, for an adopted child, indicate the date of adoption. (year / month / day)

If not, please indicate when the child **began** living with you, if applicable. (year / month / day)

If the child **does not** live with you, please specify the reason. _____

If there is not enough space, provide the additional information on a separate sheet.

11.2 Is an orphan's pension or a pension for a disabled person's child being paid under the Québec Pension Plan or the Canada Pension Plan for any of the children named above? ☐ Yes ☐ No

If so, please indicate under which social insurance number. ____ ____ ____

11.3 If the children are yours, **but do not live with you**, indicate the amounts that you provide each month for their needs (support payments, if any, school fees, medical or dental expenses, clothing, school supplies, etc.).

____ $ a month

Indicate your social insurance number

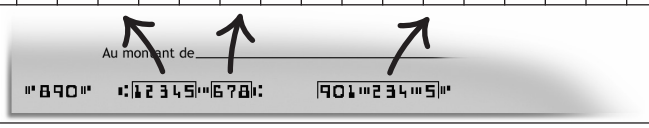
12. Payment by direct deposit

Please provide your banking information to sign up for direct deposit. Your benefits will be paid directly into your bank account at a financial institution in Canada.

The account provided must be in your name or that of the beneficiary if you are applying on his or her behalf.

If you already receive a pension under the Québec Pension Plan by direct deposit, your benefits will be deposited in the same bank account. If so, you do not need to fill out this section.

Name of your financial institution	Branch number (transit) / Bank or caisse number / Account number (folio)
Address of your financial institution	



13. Declaration and signature

I declare that all information given on this application is true and correct.

I agree to inform Retraite Québec if there is any change in my work situation or my state of health between now and the time a decision is rendered.

Signature _____ Date year month day

If you completed and signed the form for the person applying for the benefits, please provide the following information.

Why was the person unable to complete and sign the application?

_____

Are you related to the applicant? ☐ No ☐ Yes. If so, how? _____

In what capacity did you sign (guardian, mandatary, etc.)? _____

Sex	Family name	Given name
☐ F ☐ M	Address (number, street, apt.)	

City	Province	Country	Postal code

Telephone

Home (area code) Other (area code) Extension

If you are an individual, you must also provide the following information:

Your social insurance number	Your date of birth (year month day)	Your mother's family name at birth (last name only)

In order to avoid delays in processing your application, be sure you have:

- **duly completed all sections of the form**;
- **provided your social insurance number where indicated**;
- **signed** this form;
- **completed and signed** the enclosed **Consent Regarding the Release of Medical, Psychosocial and Administrative Information** form.

0100009 LA

Retraite Québec

Consent Regarding the Release of Medical, Psychosocial and Administrative Information

Indicate your social insurance number ▶

Indicate your health insurance number ▶

1. Identification

Sex	Family name	Given name	Date of birth (year / month / day)
☐ F ☐ M	Family name at birth, if different	Given name at birth, if different	
Your mother's family name at birth		Her given name	
Your father's family name		His given name	

2. Consent and signature

I am providing consent authorizing any physician, health professional, health care facility or social services institution to release to Retraite Québec any pertinent medical, psychosocial or administrative information concerning me so that Retraite Québec will have all the information needed to process my application for disability benefits under the Québec Pension Plan.

This consent is also given with respect to my employers, the Commission des normes, de l'équité, de la santé et de la sécurité du travail, the Société de l'assurance automobile du Québec, the Secrétariat du Conseil du trésor, the Secrétariat de la santé et des services sociaux, the Services-conseils aux gestionnaires des réseaux de l'éducation, as well as any administrator of an insurance plan to which I have applied for benefits related to my state of health.

Unless revoked by me in writing, this consent shall be in effect, even in the event of my death, until a final decision is rendered by Retraite Québec. The consent covers all the medical, psychosocial and administrative information held before the date of the consent and any obtained between the date of the consent and the date of the final decision.

Signature _____ Date (year / month / day)

Note:

The original consent remains on file at Retraite Québec. A certified true copy of the original shall be considered to be authentic, pursuant to section 25 of the *Act respecting the Québec Pension Plan*.

Print

Medical Report

Notice to the applicant

Before giving this form to the physician, **complete section 1, Information about the applicant's identity** and enter your social insurance number at the top of each page.

Note: Send this page with the medical report to your physician. It contains information the physician will need to complete the medical report.

Notice to the physician

Disability benefits can be paid to a person who is under 65 years of age, who has contributed to the Québec Pension Plan for the required number of years and who has been declared disabled.

Under section 95 of the *Act respecting the Québec Pension Plan*, a person can be deemed to be disabled if he or she meets the following two conditions:

- The medical condition is **severe** and prevents the person from doing any type of work on a full-time basis;
- The medical condition is **permanent**. A disability is permanent if it is of **indefinite duration** with no possibility of improvement.

Persons age 60 to 65 can also be entitled to a disability pension if they are no longer able to do their usual work on account of a disability. However, they must show that they recently worked.

The fact that a person has been deemed to be disabled by an insurance company or by another private or government agency does not automatically entitle him or her to disability benefits under the Québec Pension Plan, since the requirements could be different.

As of 2013, **persons under age 65 who are receiving a retirement pension** under the Plan can receive an additional amount for disability if they are unable to do any type of work on a full-time basis. However, they must show that they recently worked.

Persons who work as an intermediate resource or a family-type resource and take in children or adults in their principal place of residence can now contribute to the Plan and be eligible for disability benefits.

The information that you give in this report will allow our medical advisor to determine whether the person meets the requirements of the *Act respecting the Québec Pension Plan*.

Invoices

The medical examination is an insured act, pursuant to paragraph f of section 22 of the *Regulation respecting the application of the Health Insurance Act*.

Any professional fees for preparing the report should be billed to the patient.

Additional information

To aid you in preparing the medical report, consult the guide, available in French only, entitled ***L'invalidité dans le Régime de rentes – Guide du médecin traitant.*** The guide details the information needed by the medical advisor to assess the application for disability benefits. If you do not have a copy, see our Web site.

If you have questions, contact a physician at one of the following numbers (the numbers are for physician use only)**:**

Québec region: 418 657-8709, extension 3252
Toll-free: 1 888 249-5137, extension 3252

Note: This Medical Report form is available on our Web site at **www.retraitequebec.gouv.qc.ca**. You can complete it electronically.

Please return the completed form to:
Retraite Québec, Case postale 5200, Québec (Québec) G1K 7S9

Retraite Québec

0100050 LE

Retraite Québec

Medical report

Applicant's social insurance number

1. Information about the applicant's identity

Sex	Family name	Given name
☐ F ☐ M	Family name at birth, if different	Given name at birth, if different

Date of birth (year / month / day)	Health insurance number

Address (number, street, apt.)

City	Province	Country	Postal code

Telephone

Home (area code) | Other (area code) | Extension

2. Medical history and current disease

Since when has the applicant been your patient?

Relevant medical history.

Describe the current physical or mental disorders that result in an inability to work (symptoms, **onset of disease**, course, treatment to date). **Indicate all the pertinent dates**.

If you need more space, provide the additional information in section 9.

Applicant's social insurance number

3. Clinical examination

Date of the examination (year / month / day)	Height	Weight	Blood pressure

Describe the clinical signs related to your patient's **main** health problems. (If needed, consult the *Guide du médecin traitant*.)

1. General appearance (posture, gait, etc.)
2. Head, neck, thyroid, sensory organs
3. Lymph nodes
4. Breasts
5. Chest and lungs
6. Heart and blood vessels (indicate functional class)
7. Abdomen
8. Genital organs
9. Spine and extremities
10. Nervous system
11. Mental health

If you need more space, provide the additional information in section 9.

4. Investigations

What investigations have been made and what results were obtained? **Enclose** supporting documents (X-rays, pathology exams, exercise stress tests, respiratory function tests, etc.).

5. Other information

To your knowledge, are there any other medical documents that we could consult? If yes, specify.

☐ Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST)

☐ Société de l'assurance automobile du Québec (SAAQ)

☐ Insurance company. Give the name of the company: _____

☐ Hospital. Name the hospital: 1. _____ Approximate date (year / month) _____

2. _____ Approximate date _____

3. _____ Approximate date _____

☐ Other institution _____ Approximate date _____
(Rehabilitation centre, physical therapy clinic, CLSC, etc.)

Applicant's social insurance number

6. Diagnosis and prognosis

Diagnosis	Prognosis

7. Treatment

Is your patient taking any medication? ☐ No ☐ Yes. Indicate the dosage and frequency.

Is your patient receiving or has your patient received other treatments? ☐ No ☐ Yes. Specify.

Are other consultations, investigations or treatments planned? ☐ No ☐ Yes. Specify.

8. Ability to work

Complete this section even if your patient is retired (see the **Notice to the physician** at the beginning of this form).

Is your patient fit to drive a motor vehicle? ☐ No ☐ Yes

Have you recommended that he or she stop working? ☐ No ☐ Yes. Why and for how long?

Can your patient now (or will your patient **eventually** be able to) return to his or her **usual work**? ☐ Yes ☐ No. Why?

From a strictly medical standpoint, can your patient now (or will your patient eventually be able to) **do other work**? ☐ Yes ☐ No. Why?

If applicable, **since when** has his or her physical or mental condition prevented him or her from working? _____

Applicant's social insurance number

9. Observations or comments

If you need more space, provide the additional information on a separate piece of paper. Be sure to indicate the applicant's social insurance number.

10. Others considerations

Indicate what medical information, if any, cannot be given to your patient without risk of causing him or her serious harm.

When can your patient be given this information? _____

11. Physician's declaration

Family name	Given name	Licence number

Address	Postal code

Telephone (area code) Extension Fax (area code)

☐ General practitioner

☐ Specialist. Specify: _____

I declare that the information given in this report is true and complete and that the patient's condition as noted herein is that which I observed at the time of my clinical examination.

Physician's signature _____ Date (year / month / day)