COMMISSION DE LA CONSTRUCTION DU QUÉBEC

REQUEST FOR DISABILITY BENEFITS

DECLARATION OF EMPLOYEE

21

1. IDENTIFICATION OF EMPLOYEE

CCQ client number or social insurance number		Date of birth (YYYY-MM-DD)
Last name		First name
No.	Street	Apartment no.
City	Province	Postal code
Are you? ☐ Right-handed ☐ Left-handed	Telephone number	Cell number

2. INFORMATION REGARDING THE DISABILITY

a) Has your disability ended? ☐ Yes ☐ No	If so, on what date? (YYYY-MM-DD)
b) Since your disability began, have you tried to resume your work? ☐ Yes ☐ No	Another job? ☐ Yes ☐ No
If so, for which period? (YYYY-MM-DD) to (YYYY-MM-DD) :	Description
c) Do you plan to resume your work? ☐ Yes ☐ No If not, why?	d) Do you plan to take another job? ☐ Yes ☐ No If not, why?
e) Explain how your disability prevents you from working at this time.	

3. INFORMATION ON OTHER ACTIVITIES

a) Have you engaged in lucrative activities since your disability began? ☐ Yes ☐ No	If so, for which period? (YYYY-MM-DD) to (YYYY-MM-DD)
Description	

4. TREATMENTS

Are you waiting for:

a) An examination (x-rays, laboratory, magnetic resonance, etc.)	☐ Yes ☐ No	Date planned (YYYY-MM-DD)		
		Specify		
b) A treatment (physiotherapy, occupational thérapy, infiltration, etc.)	☐ Yes ☐ No	Date planned (YYYY-MM-DD)		
		Specify		
c) A consultation with one or more physicians (general practitioner, specialist, etc.)	☐ Yes ☐ No	Name of physician	Specialty	Date planned (YYYY-MM-DD)
		Name of physician	Specialty	Date planned (YYYY-MM-DD)

SPACE RESERVED FOR THE CCQ

ID	☐ LT ☐ AI ☐ M038 ☐ M058

This document is available in adapted media upon request.

5. IDENTIFICATION OF ATTENDING PHYSICIANS

Name	Specialty	Date of last visit (YYYY-MM-DD)	Date of next visit (YYYY-MM-DD)
Name	Specialty	Date of last visit (YYYY-MM-DD)	Date of next visit (YYYY-MM-DD)
Name	Specialty	Date of last visit (YYYY-MM-DD)	Date of next visit (YYYY-MM-DD)

6. INFORMATION ON INCOME AND BENEFITS

Do you receive disability or pension benefits, or have your filed a request, or do you intend to file a request at:

Please answer each question		Date of request (YYYY-MM-DD)	File or request no.	Request accepted	Request denied	Request under study	In appeal of decision
Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST)	☐ Yes ☐ No			☐	☐	☐	☐
Act respecting occupational accidents or diseases in force in another province or foreign country (ex.: United States)	☐ Yes ☐ No			☐	☐	☐	☐
Loi sur l'indemnisation des victimes d'actes criminels (IVAC)	☐ Yes ☐ No			☐	☐	☐	☐
Société de l'assurance automobile de Québec	☐ Yes ☐ No			☐	☐	☐	☐
Employment insurance act (Employment and Social Development Canada) or similar act in force in a foreign country (ex.: United States)	☐ Yes ☐ No			☐	☐	☐	☐
Retraite Québec	☐ Yes ☐ No			☐	☐	☐	☐
Canada pension plan	☐ Yes ☐ No			☐	☐	☐	☐
Construction industry pension plan	☐ Yes ☐ No			☐	☐	☐	☐
Other group retirement plan	☐ Yes ☐ No			☐	☐	☐	☐
Other individual or group disability Insurance plan	☐ Yes ☐ No			☐	☐	☐	☐
Other income (ex.: Employment, Severance pay, etc.) Specify:	☐ Yes ☐ No			☐	☐	☐	☐

If you have answered "yes" to one of these questions, a reduction of benefits (taking your income into account) or an exclusion may apply, in accordance with the regulation respecting complementary social benefit plans in the construction industry.

Note : if you have entailed expenses for the completion of this form by your practitioner, médic may reimburse the maximum amount to which you are entitled. If applicable, please join the original of your receipt to this form.

7. CERTIFICATION

I certify that all the information provided in support of my request for disability insurance benefits and/or credit hours is accurate.

Signature _____ Date (YYYY-MM-DD) _____

8. AUTHORIZATION

I hereby authorize any person or legal entity dispensing services of a medical nature (physician, hospitals), as well as insurance companies, investigation bureau, employers, the bureau de renseignements médicaux, the commission des normes, de l'équité, de la santé et de la sécurité du travail, the Direction de l'indemnisation des victimes d'acte criminel, the Régie de l'assurance maladie du Québec, the Société de l'assurance automobile du Québec, Retraite Québec, Service Canada, and Employment and Social Development Canada to transmit to the Commission de la construction du Québec (CCQ) or to its authorized representatives all the information they possess on or about the undersigned regarding my request for disability insurance benefits and/or credit hours.

The information thus transmitted to the CCQ will be used solely for purposes of the study of my request for disability insurance benefits and/or credit hours, in compliance with the provisions of the regulation respecting complementary social benefit plans in the construction industry, however, this information may be disclosed to any person or legal entity participating in the study of this request, or to other persons when required by law or when expressly authorized by the undersigned.

The present authorization or a copy hereof will be deemed valid for the duration of the study of my request.

Signature _____ Date (YYYY-MM-DD) _____

Please send this form and the supporting documentation to the following address:

Commission de la construction du Québec
Section assurance invalidité, Case postale 2515, succursale Chabanel, Montréal (Québec) H2N 0C7

Print

COMMISSION DE LA CONSTRUCTION DU QUÉBEC

REQUEST FOR DISABILITY BENEFITS

PHYSICIAN'S STATEMENT

21

1. IDENTIFICATION OF EMPLOYEE

Last name	First name	Date of birth (YYYY-MM-DD)

2. CIRCUMSTANCES

If you have not already answered these questions in previous declarations, or if the object is a new medical condition, you must complete this section, otherwise, go to section 3.

a) In your opinion, could the affliction be attributable to: ☐ Occupational accident ☐ Occupational disease ☐ Motor vehicle accident ☐ Other accident ☐ Other disease

b) Date the symptoms began or date of accident (YYYY-MM-DD)	Date total disability began (YYYY-MM-DD)
c) Has this patient ever suffered from an affliction of this kind before? ☐ Yes ☐ No	If so, on what date? (YYYY-MM-DD)

3. DIAGNOSIS

a) Primary	b) Secondary
c) Subjective symptoms	
d) Objective signs	
e) Assessment of the patient's condition ☐ Improved ☐ Deteriorated ☐ Stable ☐ Comments:	
f) Results of the investigations requested (examinations, x-rays, ekg, etc.)	Date (YYYY-MM-DD)

4. TREATMENT

a) Date of first visit (YYYY-MM-DD)	b) Date of last visit (YYYY-MM-DD)	c) Date of next visit (YYYY-MM-DD)
d) Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other	Specify	

e) Nature of prescribed treatment	Current	To come

f) Expected duration of treatment	Current	Beginning	End	Frequency

g) Prescribed medication and dosage	h) Patient's response to treatment
i) Does the patient follow the recommended treatment? ☐ Yes ☐ No	If not, please specify
j) What is your prognosis?	k) Have you referred this person to another physician? ☐ Yes ☐ No — Date (YYYY-MM-DD)
Name of physician	Specialty
l) Date of surgery, if applicable (YYYY-MM-DD)	Description

5. PHYSICAL INCAPACITY

a) Is the patient?

- ☐ Up and about
- ☐ Confined to home
- ☐ Bedridden
- ☐ Hospitalized

- ☐ Category 1 - (no restriction - capable of continued physical activity 0-10%)
- ☐ Category 2 - (slight restriction - capable of moderate physical activity 15-30%)
- ☐ Category 3 - (moderate restriction - capable of light physical activity 35-55%)
- ☐ Category 4 - (marked restriction - capable of minimal physical activity 60-70%)
- ☐ Category 5 - (severe restriction - incapable of even minimal physical activity 75-100%)

6. PSYCHOLOGICAL INCAPACITY (IF RELATED TO DISABILITY)

a) Date psychological total disability began (YYYY-MM-DD)

b) Please provide your multiaxial assessment according to the DSM-IV

Axe 1: _____ Axe 2: _____

Axe 3: _____ Axe 4: _____

Axe 5: _____

c) Please indicate the category in which you would place your patient at this time:

- ☐ Category 1 - (no restriction - may face stressful and social situations)
- ☐ Category 2 - (slight restriction - may face most stressful and social situations)
- ☐ Category 3 - (moderate restriction - may face only limited stressful or social situations)
- ☐ Category 4 - (marked restriction - unable to face stressful or social situations)
- ☐ Category 5 - (severe restriction - suffers an important loss of psychological and social abilities)

7. HEART CONDITION (IF RELATED TO DISABILITY)

a) Functional capacity ☐ Category 1 - (no restriction) ☐ Category 2 - (slight restriction) ☐ Category 3 - (marked restriction) ☐ Category 4 - (total restriction)

b) Blood pressure (last visit) systolic/diastolic

8. INCAPACITY

a) Is this person **able** to conduct **the tasks usually linked to his or her position fulltime**? ☐ Yes ☐ No

b) If so, what are the objective medical reasons that prevent this person from doing so?

c) Are there any functional limitations? ☐ Yes ☐ No

If so, are these: ☐ Permanent ☐ Temporary

Specify the duration

Please describe these

d) Date on which this person may resume **the tasks usually linked to his or her position fulltime** (YYYY-MM-JJ)

e) Is this person **able** to occupy **a lucrative position** adapted to his or her medical condition (ex.: Light or sedentary work)? ☐ Yes ☐ No

f) If so, what are the objective medical reasons that prevent this person from doing so?

g) Date on which this person will be able to occupy a lucrative position adapted to his or her medical condition (YYYY-MM-DD)

9. REHABILITATION

a) Is your patient able to participate in a rehabilitation program aiming reinstatement in the workplace? ☐ Yes ☐ No

b) Do you recommend that your patient follow a physical reconditioning program? ☐ Yes ☐ No

c) Would you agree to refer your patient to an occupational therapist for an assessment of his or her functional capacities? ☐ Yes ☐ No

d) Do you recommend that your patient redirect his or her career in another job? ☐ Yes ☐ No

e) Do you have any suggestions that could further your patient's return to work? ☐ Yes ☐ No

If so, what are your suggestions?

10. COMMENTS

11. IDENTIFICATION OF PHYSICIAN

Name of physician

Address

☐ General practitioner ☐ Specialist Specify: _____

Permit no.

Telephone no.

Signature of physician

Date (YYYY-MM-DD)

Fax no.