CNESST

APPENDIX TO THE WORKER'S CLAIM
OCCUPATIONAL DISEASE – REPETITIVE MOVEMENTS
Occupational health and safety

Filling out the Form

You should fill out this form if you believe that you have contracted an occupational disease at work caused by repetitive movements.

This form contains specific and important questions necessary for processing your claim for an occupational disease. It must be sent to the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) office at the same time as the *Worker's Claim* form if you have not already sent it to us.

Your health insurance number *must* appear on this form. If you require assistance to fill out this form, please contact the CNESST at 1 844 838-0808.

Regarding employment history:

- write the name and address of all employers where you contracted your disease, beginning with your current or most recent employer;
- if you require more space, use a separate sheet of paper or fill out another form.

It is extremely important that you send us all pertinent information related to your claim. Use the section titled *Comments* or attach another document if necessary. We recommend that you keep a photocopy of this form.

Protection of Personal Information

In light of Section 65 of the *Act respecting Access to Documents Held by Public Bodies and the Protection of Personal Information*, the CNESST ensures you that all information gathered while processing this document, as well as that which will be added to your file subsequently, will be treated confidentially and will be available only to those persons designated under the declaration of personal information files that you may consult at the Commission d'accès à l'information. Some information may however be communicated or obtained without your consent, as specified in the *Act respecting Industrial Accidents and Occupational Diseases*, or under agreements between various bodies as determined by the *Act respecting Access to Documents Held by Public Bodies and the Protection of Personal Information*.

All information requested is necessary for processing your claim. If you refuse to provide this information your claim could be rejected.

As well, please note that the *Act respecting Access to Documents Held by Public Bodies and the Protection of Personal Information* (in sections 83, 85 and 89-93) makes provision for your rights of access and rectification. In order to obtain your file, please contact your CNESST regional office. If necessary, you may send a request to the person in charge of access to and protection of personal information at the CNESST.

CNESST

APPENDIX TO THE WORKER'S CLAIM
OCCUPATIONAL DISEASE – REPETITIVE MOVEMENTS
Occupational health and safety

Worker's file No.

Health insurance No.

Date of event Y Y Y Y M M D D

A. Identification of worker

Surname (as shown on birth certificate)	First name

B. Employment history

Current job (or last job held)

From	To	Job or position
Y Y Y Y M M D D	Y Y Y Y M M D D	

Employer's name (business name)

Address of the establishment to which the worker is attached — Number — Street — Suite

City — Province — Country — Postal code

Describe the duties you performed and, for those that required repetitive movements, describe the movements executed (attach a diagram if necessary).

For the movements that required repetition, please indicate the articulations (joints) involved: shoulder, elbow, wrist, knee, etc.
Also, specify whether it was the left or right side.

For how long have you been working in these conditions?

Describe the tools or instruments that you use. — Number of hours per day

How much time do you spend each normal workday executing these movements?	How many times per minute do you make these movements?	Number of hours per day	Number of days per week	Number of weeks per year

Do you have time to rest? ☐ Yes ☐ No	If yes, how many times per day?	Total amount per day	Do you use force to make these repetitive movements? ☐ Yes ☐ No

Describe the position that you use most often to perform your work (attach a diagram if necessary).

Were there any changes made to the performance of your duties or the way your work is organized that, in your opinion, could have led to your condition? ☐ Yes ☐ No — If yes, list these changes and when they were made.

In your opinion, did other workers in the same establishment have the same health problems? ☐ Yes ☐ No

Are you exposed to vibrations? ☐ Yes ☐ No	Are you exposed to cold? ☐ Yes ☐ No

CNESST

APPENDIX TO THE WORKER'S CLAIM
OCCUPATIONAL DISEASE – REPETITIVE MOVEMENTS
Occupational health and safety

Former job

From (Y Y Y Y M M D D)	To (Y Y Y Y M M D D)	Job or position

Employer's name (business name)

Address of the establishment to which the worker is attached — Number — Street — Suite

City — Province — Country — Postal code

Describe the duties you performed and, for those that required repetitive movements, describe the movements executed (attach a diagram if necessary).

For the movements that required repetition, please indicate the articulations (joints) involved: shoulder, elbow, wrist, knee, etc.
Also, specify whether it was the left or right side.

How long did you work in these conditions?

Describe the tools or instruments that you used. — Number of hours per day

How much time did you spend each normal workday executing these movements?	How many times per minute did you make these movements?	Number of hours per day	Number of days per week	Number of weeks per year

Did you have time to rest? ☐ Yes ☐ No — If yes, how many times per day? — Total amount per day

Did you use force to make these repetitive movements? ☐ Yes ☐ No

Describe the position that you used most often to perform your work (attach a diagram if necessary).

Were there any changes made to the performance of your duties or the way your work was organized that, in your opinion, could have led to your condition? ☐ Yes ☐ No — If yes, list these changes and when they were made.

In your opinion, did other workers in the same establishment have the same health problems? ☐ Yes ☐ No

Were you exposed to vibrations? ☐ Yes ☐ No

Were you exposed to cold? ☐ Yes ☐ No

CNESST

APPENDIX TO THE WORKER'S CLAIM
OCCUPATIONAL DISEASE – REPETITIVE MOVEMENTS
Occupational health and safety

Former job

From (Y Y Y Y M M D D)	To (Y Y Y Y M M D D)	Job or position

Employer's name (business name)

Address of the establishment to which the worker is attached — Number — Street — Suite

City — Province — Country — Postal code

Describe the duties you performed and, for those that required repetitive movements, describe the movements executed (attach a diagram if necessary).

For the movements that required repetition, please indicate the articulations (joints) involved: shoulder, elbow, wrist, knee, etc.
Also, specify whether it was the left or right side.

How long did you work in these conditions?

Describe the tools or instruments that you used. — Number of hours per day

How much time did you spend each normal workday executing these movements?	How many times per minute did you make these movements?	Number of hours per day	Number of days per week	Number of weeks per year

Did you have time to rest? ☐ Yes ☐ No — If yes, how many times per day? — Total amount per day

Did you use force to make these repetitive movements? ☐ Yes ☐ No

Describe the position that you used most often to perform your work (attach a diagram if necessary).

Were there any changes made to the performance of your duties or the way your work was organized that, in your opinion, could have led to your condition? ☐ Yes ☐ No — If yes, list these changes and when they were made.

In your opinion, did other workers in the same establishment have the same health problems? ☐ Yes ☐ No

Were you exposed to vibrations? ☐ Yes ☐ No

Were you exposed to cold? ☐ Yes ☐ No

CNESST

APPENDIX TO THE WORKER'S CLAIM
OCCUPATIONAL DISEASE – REPETITIVE MOVEMENTS
Occupational health and safety

Former job

From (Y Y Y Y M M D D)	To (Y Y Y Y M M D D)	Job or position

Employer's name (business name)

Address of the establishment to which the worker is attached — Number — Street — Suite

City — Province — Country — Postal code

Describe the duties you performed and, for those that required repetitive movements, describe the movements executed (attach a diagram if necessary).

For the movements that required repetition, please indicate the articulations (joints) involved: shoulder, elbow, wrist, knee, etc.
Also, specify whether it was the left or right side.

How long did you work in these conditions?

Describe the tools or instruments that you used. — Number of hours per day

How much time did you spend each normal workday executing these movements?	How many times per minute did you make these movements?	Number of hours per day	Number of days per week	Number of weeks per year

Did you have time to rest? ☐ Yes ☐ No — If yes, how many times per day? — Total amount per day

Did you use force to make these repetitive movements? ☐ Yes ☐ No

Describe the position that you used most often to perform your work (attach a diagram if necessary).

Were there any changes made to the performance of your duties or the way your work was organized that, in your opinion, could have led to your condition? ☐ Yes ☐ No — If yes, list these changes and when they were made.

In your opinion, did other workers in the same establishment have the same health problems? ☐ Yes ☐ No

Were you exposed to vibrations? ☐ Yes ☐ No

Were you exposed to cold? ☐ Yes ☐ No

CNESST

APPENDIX TO THE WORKER'S CLAIM
OCCUPATIONAL DISEASE – REPETITIVE MOVEMENTS
Occupational health and safety

Former job

From (Y Y Y Y M M D D)	To (Y Y Y Y M M D D)	Job or position

Employer's name (business name)

Address of the establishment to which the worker is attached — Number — Street — Suite

City — Province — Country — Postal code

Describe the duties you performed and, for those that required repetitive movements, describe the movements executed (attach a diagram if necessary).

For the movements that required repetition, please indicate the articulations (joints) involved: shoulder, elbow, wrist, knee, etc.
Also, specify whether it was the left or right side.

How long did you work in these conditions?

Describe the tools or instruments that you used. — Number of hours per day

How much time did you spend each normal workday executing these movements?	How many times per minute did you make these movements?	Number of hours per day	Number of days per week	Number of weeks per year

Did you have time to rest? ☐ Yes ☐ No — If yes, how many times per day? — Total amount per day

Did you use force to make these repetitive movements? ☐ Yes ☐ No

Describe the position that you used most often to perform your work (attach a diagram if necessary).

Were there any changes made to the performance of your duties or the way your work was organized that, in your opinion, could have led to your condition? ☐ Yes ☐ No — If yes, list these changes and when they were made.

In your opinion, did other workers in the same establishment have the same health problems? ☐ Yes ☐ No

Were you exposed to vibrations? ☐ Yes ☐ No

Were you exposed to cold? ☐ Yes ☐ No

CNESST

APPENDIX TO THE WORKER'S CLAIM
OCCUPATIONAL DISEASE – REPETITIVE MOVEMENTS
Occupational health and safety

C. Information related to your occupational disease

Have you already consulted medical personnel regarding the health problems for which you are making a claim? ☐ Yes ☐ No

If yes, please list the names and addresses of physicians consulted and/or the health establisments where you have had examinations performed.

1	Name		Specialty	
	Address Number Street	Suite	Examinations performed	Date Y Y Y Y M M D D
	City Province Country	Postal code		
2	Name		Specialty	
	Address Number Street	Suite	Examinations performed	Date Y Y Y Y M M D D
	City Province Country	Postal code		
3	Name		Specialty	
	Address Number Street	Suite	Examinations performed	Date Y Y Y Y M M D D
	City Province Country	Postal code		
4	Name		Specialty	
	Address Number Street	Suite	Examinations performed	Date Y Y Y Y M M D D
	City Province Country	Postal code		
5	Name		Specialty	
	Address Number Street	Suite	Examinations performed	Date Y Y Y Y M M D D
	City Province Country	Postal code		

Note: If you need more space, please use the *E.Comments* section.

D. Supplementary information

Has an accident likely caused your condition?

☐ Yes ☐ No If yes, describe it.

Are you? ☐ Right-handed ☐ Left-handed	Have you already made a claim with the CNESST for the same health problem? ☐ Yes ☐ No If yes, when?

E. Comments

Please provide all information that you consider pertinent to processing your claim and that could be related to your occupational disease.

F. Signature

I declare that the above information is complete and genuine.	Worker's signature	Date Y Y Y Y M M D D