CSST

ELECTION UNDER THE ACT RESPECTING INDUSTRIAL ACCIDENTS AND OCCUPATIONAL DISEASES
(SECTION 452 OF THE ACT)

Identification of the Worker			
Surname at birth, First name			Telephone Number
Address No Street			
City, Municipality	Province, Country		Postal Code
Date of Birth	**Date of Event**	**Social Insurance Number**	**Worker's CSST file number**
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I, _____, declare that I suffered an employment injury
(Name of Worker)

on _____, in _____ when I was working
(Day, Month, Year) (Province, Territory or, if outside Canada, Country)

for _____
(Name and Address of Employer)

_____.

Or (in case of death)

I am the _____ of _____who died on
(Spouse, Dependent, Father, Mother, Succession) (Name of Worker)

_____ following an employment injury sustained in _____ while
(Day, Month, Year) (Province, Territory or, if outside Canada, Country)

working for _____
(Name and Address of Employer)

_____.

I must choose between the benefits provided under the Act respecting industrial accidents and occupational diseases (Quebec Act) and the benefits provided under the laws of_____.
(Province other than Quebec, Territory or, if outside Canada, Country)

I declare that I am making a claim for this employment injury with the _____ Board
(Province, Territory or, if outside Canada, Country)
and I am advising the Commission de la santé et de la sécurité du travail accordingly. I also declare that I have not claimed for compensation from another organization for the same employment injury.

If this claim is accepted, I waive in relation to this employment injury all rights to compensation under any other legislation.

Signature: _____ Date: _____
(Worker or, in case of death, beneficiary) (Day, Month, Year)

PROTECTION OF PERSONAL INFORMATION

In accordance with the Act respecting access to documents held by public bodies and the protection of personal information, the Commission de la santé et de la sécurité du travail hereby advises you that the nominative information collected on this form is confidential. However, it may be disclosed without your consent pursuant to the exceptions stipulated in the Act respecting industrial accidents and occupational disease and the Act respecting access to documents held by public bodies and the protection of personal information.

You are hereby given notice that in accordance with section 67 of the Act respecting access to documents held by public bodies and the protection of personal information, this form will be transmitted to the relevant Workers Compensation Board in the place where the accident occured, or the place where you are domiciled, or the place where exposure may have contributed to your occupational disease.