Société de l'assurance automobile Québec

Avec vous, au cœur de votre sécurité

Training and Work Experience

Erase

Accident victim

Last name	First name	Claim number

1. Work experience

Enter the required information about the jobs you have held over the past 5 years.
(Please refer to the dates indicated in the enclosed letter. If the space provided is insufficient, attach a separate sheet.)

Employment period (beginning with the most recent)		**Position held**	**Business or organization**	**Number of hours worked per week** (not including overtime	**Number of hours of work per week considered to be full-time by the business or organization**	**Gross income**
From (Year-Month)	**To** (Year-Month)					
						$/ ☐h ☐weekly
						$/ ☐h ☐weekly
						$/ ☐h ☐weekly
						$/ ☐h ☐weekly
						$/ ☐h ☐weekly
						$/ ☐h ☐weekly

Over the past five years, have there been periods when you were unable to hold a job due to illness a workplace accident, preventative leave, maternity leave, etc.? ☐ Yes ☐ No If so, complete the chart below:

Period		**Reason**
From (Year-Month)	**To** (Year-Month)	

2. Training

a) **Over the past five years, have you been a full-time student?** ☐ Yes ☐ No If so, complete the chart below:

Period		**Program of study**
From (Year-Month)	**To** (Year-Month)	

b) **Have you obtained your secondary school diploma?** ☐ Yes ☐ No

c) **Have you obtained other diplomas or degrees?** ☐ Yes ☐ No If so, complete the chart below:

Year obtained	**Title of the diploma or degree**	**Year obtained**	**Title of the diploma or degree**
	☐DVS/AVS ☐University ☐ACS/DCS ☐Other		☐DVS/AVS ☐University ☐ACS/DCS ☐Other
	☐DVS/AVS ☐University ☐ACS/DCS ☐Other		☐DVS/AVS ☐University ☐ACS/DCS ☐Other

Did you hold a valid professional licence or certificate of qualification at the time of the accident?
☐ Yes ☐ No If so, specify: _____

Licence/certificate number: _____ Expiry date (Year-Month-Day) : _____

Were you a member of a professional corporation at the time of the accident?
☐ Yes ☐ No If so, specify: _____ Membership number: _____

3. Physical and psychological abilities

▶ **PRIOR TO THE ACCIDENT, had a health care professional recommended that you permanently avoid making certain movements or doing certain tasks?**

☐ Yes ☐ No If so, specify:
☐ Lifting loads weighing more than: _____ ☐ lbs ☐ kg
☐ Making a movement (e.g. crouching, lifting arms above head, etc.): _____
☐ Remaining in the same position for prolonged periods (sitting or standing): _____
☐ Other : _____

Declaration

I declare in good faith that the information provided is accurate.

Signature of the accident victim (if of full age) or their representative

Date (Year-Month-Day)

THERE ARE THREE WAYS TO SUBMIT A DOCUMENT:
Through the Reimbursement of Expenses and Document Submission online service:
saaq.gouv.qc.ca/envoidocuments
By fax: 1-866-289-7952
By mail: Société de l'assurance automobile du Québec
Case postale 2500, succursale Terminus
Québec (Québec) G1K 8A2

Keep the original or a copy for your files.

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