CSST Commission de la santé et de la sécurité du travail du Québec

Preventive withdrawal and re-assignment certificate for a pregnant or breast-feeding worker

CSST file No.

A - Identification of worker and purpose of consultation

Surname and given name at birth | Medicare number

Address | Social insurance number

Postal code | Telephone number (Area code)

Application category: ☐ Pregnancy — Expected delivery date (Year Month Day) | ☐ Breast-feeding — Date of birth of breast-fed child (Year Month Day)

Nature of the danger apprehended by the worker — Describe:

Signature of worker

B - Identification of workplace and description of worker's occupation

Employer's firm name

Address of workplace | Postal code

Place and department where worker carries out duties | Title of position

Name and position of the person with whom we may communicate in the business | Telephone number (Area code)

C - Compulsory consultation under the Act

(The physician in charge of health services for the establishment need not complete this section if he issues the certificate.)

Name of physician consulted | as ☐ Physician in charge of health services ☐ Head of CHD ☐ Designated physician

Name of community health department | Telephone number (Area code)

Receipt of consultation report: ☐ by telephone or ☐ in writing | Date (Year Month Day)

D - Medical report

In your opinion, what are the working conditions which are physically dangerous to the unborn child or breast-fed child or to the worker because of her pregnancy?

Is the worker medically capable of working? ☐ Yes ☐ No

IMPORTANT For preventive withdrawal or re-assignment, the worker must be capable of working.

E - Attestation

☐ I certify that the working conditions of the worker are physically dangerous for her because of her pregnancy, or for the unborn child or breast-fed child

For pregnancy only — Indicate the number of weeks of pregnancy at the date of preventive withdrawal or re-assignment

Date of preventive withdrawal or re-assignment (Year Month Day)

☐ Attending physician ☐ Physician in charge of health services | Name of physician (block letters) | Corporation No. | Telephone number (Area code)

Signature | Date (Year Month Day) | Date certificate delivered to the worker (Year Month Day)

Suggestion(s) to employer to facilitate re-assignment (working conditions and duties to be changed).

The worker must return the duly completed certificate to the employer However, the absence of suggestions made to the employer does not render the certificate invalid