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 — Area code Telephone number

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 or specialized nurse practitioner consulted — as ☐ Physician in charge of health services ☐ Head of CHD ☐ Designated physician or specialized nurse practitioner

Name of community health department — Area code Telephone number

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 or specialized nurse practitioner

Name of physician or specialized nurse practitioner (in block letters)

Corporation No.

Area code Telephone number

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.