CONTESTATION FORM

 CONTEXT

 **An administrative review was requested**

* 1. The CNESST’s administrative review decision.
* 2. The CNESST did not make a decision within 90 days after receiving the application for administrative review, the presentation of observations or the production of documents**.**

**No administrative review was requested**

* 3. A decision rendered jointly by the CNESST and Société de l’assurance automobile du Québec (SAAQ) or Indemnisation des victimes d’actes criminels (IVAC).
* 4. A decision pertaining to discriminatory measures and/or reprisals (a dismissal or other penalties), pursuant to section 32 of the *Act respecting industrial accidents and occupational diseases* (the AIAOD) and/or section 227 of the *Act respecting occupational health and safety* (AOHS)..
* 5. A decision made in keeping with the opinion of the Bureau d’évaluation médicale (BEM), a special committee (occupational lung diseases), or a committee on occupational oncological diseases.
* 6. A decision on financing (assessment, classification, costs charged).

DECISION(S) YOU WISH TO CONTEST



**Most recent decision:**

 Year Month Day

**CNESST record number in full:**

**Other numbers (as applicable):**

REASONS FOR THE CONTESTATION

**Indicate your reasons for disagreeing with the decision.**

CONTESTING PARTY: **Worker**  **[ ]  Employer [ ]  Other**  **[ ]**

**If you are a worker:**

 **Last name:** **First name:**

**If you are an employer:**

**Company name:**

**Contact name:**

**Québec Entreprise Number (NEQ): | | | | | | | | | | |**

****

**Address:**

 Number, street, city or town Postal code

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone (home):** **Cellphone:**



**Telephone (work):** **Fax:**

YOUR REPRESENTATIVE (as applicable)

**Representative name:**

**Organization, union or association:**

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**Address:**

 Number, street, city or town Postal code

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone:** **Fax:**

**OTHER PARTY**: **Worker**   **[ ]  Employer [ ]  Other**  **[ ]**

**If the party is a worker:**

**Last name:** **First name:**

**If the party is an employer:**

 **Company name:**

 **Contact name:**



**Address:**

 Number, street, city or town Postal code

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone (home):** **Cellphone:**



**Telephone (work):** **Fax:**

WITNESSES

**Do you intend to call one or more witnesses at the hearing? If so, please provide their name(s) and occupation(s).**

 **NAME** **OCCUPATION**

**1**

**2**

**3**

**4**

|  |  |
| --- | --- |
| SIGNATURE **(person contesting or representative)** | **Date** |
| X | **Year** **| | |**  | **Month** **|**  | **Day** **|**  |

**IMPORTANT: Attach a full copy of the contested decision(s), including the last page with the parties’ names and contact information.**

You can fill this form out, save it and **email** it to the Tribunal office located in the **region where the worker is domiciled**, or print the form, fill it out and mail or fax it to us. Our contact information is available in the “[Nous joindre](http://www.clp.tat.gouv.qc.ca/nous-joindre/bureaux-regionaux/)” section of our website (available in French only).