Tribunal administratif du travail
Québec

Division de la santé et de la sécurité du travail

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.

_____

_____

_____

_____

_____

Is this a record involving allegations of sexual violence? Yes ☐ **No** ☐

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: _____

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		
	Year	Month	Day
X			

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" section of our website (available in French only).