The 1986-1990 Hepatitis C Claims Centre
P.O. Box 2370, Station D
Ottawa Ontario, Canada
K1P 5W5
Tel: 1-877-434-0944

GEN 11

Activities of Employment
(COMPLETE THIS FORM FOR SOME CLAIMS FOR LOSS OF INCOME)
Strictly Private and Confidential

CLAIMANT PLEASE AFFIX HERE ONE OF THE PREPRINTED LABELS PROVIDED
*** If you do not have the labels, call 1-877-434-0944 for instructions**

CORRECTIONS ONLY:
Write any name, address corrections below, if any corrections are necessary:

The information collected in this Form will help determine the duties the disabled HCV Infected Person performed in his or her usual employment and the HCV Infected Person's level of disability.

1) The disabled HCV Infected Person is living: if you are the disabled HCV Infected Person or the Approved HCV Personal Representative of a living disabled HCV Infected Person who is a minor or a mentally incompetent adult, complete this Form and Form GEN 10 and GEN 19 to make a claim for **loss of income**.

OR

2) The disabled HCV Infected Person died on or after January 1, 1999: the Approved HCV Personal Representative must complete this Form and Form GEN 10 and GEN 19 to claim **pre-death loss of income** on behalf of the Estate of the deceased disabled HCV Infected Person. Do not complete this Form if there is no pre-death loss of income claim. **Dependants of any deceased HCV Infected Person claiming post-death loss of support only, complete Form GEN 10 and GEN 19 only and not this Form**.

Persons required to complete this Form must also have the Treating Physician complete the "Disability Section" of Tran/Hemo 2 Treating Physician Form or Tran/Hemo 2D.
Please ensure the **Treating Physician reviews this Form prior to completing the "Disability Section" of the Treating Physician Form TRAN/HEMO 2 or Form Tran/Hemo 2D assessing disability**.

SECTION A – PERSONAL INFORMATION

HCV INFECTED PERSON

1.	First Name	Middle Name/Initial	Last Name	
	Home Address	City	Province/Territory	Postal Code

APPROVED HCV PERSONAL REPRESENTATIVE

2.	First Name	Middle Name/Initial	Last Name	
	Home Address	City	Province/Territory	Postal Code

SECTION B – DESCRIPTION OF HCV INFECTED PERSON'S EMPLOYMENT

Description of the HCV Infected Person's Employment (check each box that applies):

3.	☐ Clerical	☐ Supervisory	☐ Sales	☐ Manufacturing	☐ Other _____.
	Job Title or Position:				

SECTION C – ACTIVITIES OF EMPLOYMENT

Indicate the total hours per week the HCV Infected Person performed the following activities of his or her usual employment:

4.

Task	Hours Per Week BEFORE HCV Disability	Hours Per Week (Currently or Immediately Prior to Death)
Standing		
Sitting		
Walking		
Driving		
Lifting Under 25 kg		
Lifting Over 25 kg		
Kneeling		
Typing		
Word Processing		
Writing		
Filing		
Talking on the Phone		
Other, please describe		
TOTAL	_____ **HOURS PER WEEK**	_____ **HOURS PER WEEK**

5. If at any time during the period of disability as a result of HCV infection the number of hours of employment activities the HCV Infected Person performed was **different** from that experienced currently or immediately prior to death, as provided in the answer at line 4 above, please provide details of the differences for each such time period below:

6. In cases of **temporary disability** due to HCV infection, please indicate when the HCV Infected Person first became disabled along with the date he/she ceased to be disabled.

Start Date DD/MM/YYYY	End Date DD/MM/YYY
/ /	/ /

Is/was the HCV Infected Person having difficulty with any of the following because of his/her disability as a result of HCV infection:

7.

Category	Task
Thinking	Memory ☐ Concentration ☐ Decision Making ☐ Judgment ☐
	Other ☐ Please describe any other difficulties:
Ability to Control Emotions/Behavior	Frustration ☐ Anger ☐ Depression ☐ Anxiety ☐ Fear ☐
	Other ☐ Please describe any other difficulties:
Communication Abilities	Speaking ☐ Listening ☐ Seeing ☐
	Other ☐ Please describe any other difficulties:

SECTION D-CERTIFICATION

I certify that the information provided is true and correct. I am not making any false or exaggerated claims to obtain benefits.

_____ **Date Signed**

_____ **Signature of HCV Infected Person or Approved HCV Personal Representative**