Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "B" – REQUIRED CONTENT
INITIAL ASSESSMENT REPORT

Client Name:	**Date of Referral:**
Client Identifier Number:	**Service Provider (SP):**
Client Address:	**SP – Consultant:**
Client Telephone #:	**SP – Consultant's direct telephone #:**
Date of interview with the client:	
Date of interview with the physician:	
Date of interview with employer (if appropriate):	
Service Canada VR Case Manager:	

Diagnosis:

Specific Reason for Referral:

Please ensure your report addresses the areas identified below:

1. **Psychosocial Profile**
   Subjective:
   - General impression of the client
   - General attitude of the client
   - Motivation: what are the incentives, disincentives to return to work (RTW)
   - Cognitive status
   - Emotional status

   Objective:
   - Client personal and vocational goals
   - Client perceived level of disability/capacity
   - Support available
   - Family situation and obligations

2. **Description of client's home environment**
   Note: If the client is not met in his/her own home, provide the client's reason(s) for not meeting there.

3. **Medical and Rehabilitative Interventions (May be contained in physician report)**
   - Main and secondary diagnosis(es)
   - Recent medical interventions including client's compliance and response
   - Past and current rehabilitation including client's compliance and response
   - Change in medical status since benefits granted
   - Prognosis: potential for "medical instability"
   - Signed letter by client's physician, or summary of consultant's meeting and/or telephone conversation with client's physician.
   - Special considerations, restrictions to RTW
   - List of current medications taken by client
   - Need/use of assistive devices

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "B" – REQUIRED CONTENT
INITIAL ASSESSMENT REPORT

4. **Education/Vocational Profile**
   - Previous testing (aptitude, interest, vocational, etc.) results and/or interpretation if available
   - Previous VR activities and programs
   - Formal and informal education, course, certificate, dates of completion
   - All previous work experience (occupations, duration, salary, job descriptions)
   - Transferable skills
   - Client vocational goals, expectations of a return to work program
   - Employer's willingness to accommodate the client, provide alternative work, proposed schedule and salary (if applicable)
   - Employability profile: academic skills, personal management skills, teamwork skills
   - Interests, hobbies and volunteer work
   - Volunteer work

5. **Financial situation**
   - Revenues and expenses from other sources
   - Coverage under other Programs (Student Loan, EI Program, WCB, Long-Term Disability Insurers, Auto Insurer, Social Assistance, etc.)

6. **Functional Status**
   - Provide a description of the client's past and current functional level based on the client, physician and employer (if applicable) interviews (report of employer interview to be attached if applicable) clarifying the type of impairment affecting the client and how it affects current activities: self-care work and leisure, transportation, childcare, etc.
   - List those barriers to employment and identify those that can be decreased/ minimized
   - Identify whether or not the client's goals are realistic and within the CPPD Vocational Rehabilitation Program mandate

7. **Employer interview (if applicable)**
   - Brief description of the activities performed in the client's own job and whether it is still available
   - Accommodations the employer is willing to make, if necessary
   - Availability of alternate work
   - Client's work attitude and attendance

8. **Partner interview**
   - Overview of planning and/or assessments done to date
   - Cost sharing opportunity
   - Type of resource available
   - Information sharing

Recommendations:

Prior to making any recommendations for further service or intervention, please state clearly your opinion regarding the client's rehabilitation potential. For example:

a. The client has rehabilitation potential and is likely to succeed with minimal intervention. (*Clarify if the client can return to work now with job placement assistance ;)*
b. The client has some rehabilitation potential but may require more extensive intervention due to identified barriers;
c. The client's potential is not clear and needs further exploration; or

d. The client has no rehabilitation potential and should not participate in the program.

Provide an explanation for your recommendation and justify the need for CPPD investment in a Vocational Rehabilitation Program.

Provide your opinion regarding whether or not the client remains totally disabled from performing any substantially gainful occupation, and your impression of his/her abilities.

Provide recommendations, with rationale, for activities required for next reporting period with estimated costs.

_____ _____

Consultant Signature Date

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "C" – REQUIRED CONTENT
Labour Market Analysis

Client Name:	Service Provide(SP):
Client Identifier Number:	SP Consultant:
Client Address:	SP Consultant's direct telephone #:
Client Phone #:	Date of Report:
Service Canada VR Case Manager:	

A Labour Market Survey for ___*(list type of occupation)*____ was completed by *(service provider's name)*. All labour market research was conducted on _____ (or) between _____ and _____.

JOB DESCRIPTION

Job title: NOC #:
Duties:
Skills, interests, values:
Environment/Physical Demands of the job:
Qualifications/Educational Requirements:

Researched Positions

(It is expected that three companies will be contacted by the service provider and three by the client)

Position:	Company:
Contact:	Location:
Qualifications & Responsibilities:	Physical Requirements:
Tools & Equipment Utilized:	Travel Requirements:
Security Clearance Required (yes or no):	Salary Range:
Company Benefits	Hours:
Available Positions (past, current, predicted)	Accessibility:

Repeat above group of headings for each company contacted.

Summary: (*Address whether the job market in the client's area of residence, as per the information gathered above, supports his/her career choice*)

Enclosures: Client's labour market research and job postings.

_____ _____
Consultant Signature Date

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "D" – REQUIRED CONTENT
Individual Written Rehabilitation Plan (IWRP)

Original (Y/N)_____ Revised (Y/N)____If yes, revision #_____ Date:_____

Client Name:	Service Provider (SP):
Client Identifier Number:	SP Consultant:
Client Address:	SP Consultant's direct telephone #:
Client telephone#	Service Canada VRCM:
Previous Occupation:	
Education:	
Future Job Expectation:	

Employment Goal

RTW – Same Employer
___Same Occupation
___Alternate Job
___ Modified Work

RTW – New Employer
___Same Occupation
____ Alternate Job
___ Modified Work

Self-Employment
___Same Occupation
___ Alternate Job
___ Modified Work

Vocational Rehabilitation Short & Long Term Goals:

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "D" – REQUIRED CONTENT
Individual Written Rehabilitation Plan (IWRP)

Original (Y/N)_____ Revised (Y/N)____If yes, revision #_____ Date:_____

Reference Guide for Numbering (refer to the Statement of Work):
Assessment Phase: 5.1
Planning Phase: 5.2
Intervention Phase: 5.3
Financial Services: 5.4
Client Disbursement and Travel Expenses: 8.1
Service Provider Disbursement and Travel Expenses: 8.2

#	Objective	Services/Goods/Strategies Required	Provider	Cost or Funding Source	Start Date	End Date

CPPD/Service Provider Costs:_____
Partner Costs: _____
Client Costs: _____
Total Projected IWRP Cost: _____

____ **I agree to comply and take responsibility for my own rehabilitation plan, including** maintaining contact as determined with the service provider and informing the service provider of any change(s) in my medical condition and/or life situation that will affect the progression of the rehabilitation plan. **I understand the plan may change as required throughout the rehabilitation process and will be subject to further review and signatures.**

____ **I do not accept this plan.**

Client Signature: _____ **Date:**_____

____**I agree with the rehabilitation plan as outlined. There are no medical concerns re the client's active participation in this rehabilitation plan.**

____ **I do not agree with the rehabilitation plan as outlined. Please see the rationale in the comment section.**

Physician Signature:_____ **Date:** _____

SP Consultant: _____ **Date:**_____

Partnering Agency:_____

Representative Signature:_____ **Date:**_____

SC VRCM Signature: _____ **Date:**_____

COMMENTS:_____
_____
_____

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "E" – REQUIRED CONTENT
PROGRESS REPORT

Client Name:	**Service Provider:**
Client Identifier Number :	**SP Consultant Name:**
Client Address:	**SP Consultant Direct Telephone #:**
Client Phone #:	**Date of Last Report:**
Current Phase: (Assessment, Planning, Intervention)	
SC Vocational Rehabilitation Case Manager:	

NOTE: Do not repeat or "copy and paste: information contained in previous reports or in the referral information.

1. List of all activities performed since the last progress report and **date** for each activity (the date for billable activities should match the date on the invoice).

2. Summary of Contacts:
   - Client
   - Employer
   - Physician: all medical and disability related information provided by the treating physician should be confirmed in writing and should include a date and the signature of the physician.
   - Others

3. Job Development/Placement Activities:
   - List specific employers contacted
   - Job and salary information
   - Employer response/outcome

4. Community resources used during the reporting period.
5. Degree of client's follow through and cooperation comment on the interest, motivation and specific efforts initiated by the client.
6. Barriers emerging which may delay the rehabilitation process and actions taken/ recommendations.
7. Evidence of capacity or incapacity to work.
8. Next significant milestones for client.
9. Projected costs to complete the case.
10. Specific recommendations.
11. Justification for change in vocational rehabilitation cost and/or plan.
12. Assessment on successful outcome.
13. Outcome.
14. Service Canada Vocational Rehabilitation Case Manager action requested.

_____ _____

Consultant Signature Date

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "E" – REQUIRED CONTENT
PROGRESS REPORT

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "F" – REQUIRED CONTENT
JOB SEARCH AGREEMENT

Original _____Revised _____If Yes, Revision # _____Date: _____

Client Name:	**SC Vocational Rehabilitation Case Manager:**
Client Identifier Number:	**SP Consultant:**
Client Telephone #:	**SP Consultant Direct Telephone #:**

As a component of (*client's name*) active participation in Canada Pension Plan's (CPP) Disability Vocational Rehabilitation Program, CPP has agreed to sponsor (*client name*) in a **_____ month job search** facilitated by (*Service Provider's name*) from (*date*) to (*date*).

(*Client's name*) will be provided Employer Contact Sheets by (*Service Provider*) in order to document job search efforts on a bi-weekly basis. (*Client's name*) is expected to contact a **minimum of _____ employers per day (_____ employers per week)** and to submit these to (*Service Provider*) every two weeks.

(*Client's name*) agrees to focus job search efforts in the following occupations: (list occupation(s) here).

(*Service Provider's name*) agrees to ongoing regular weekly communication with (*client's name*) to assist with the Job Search process. This assistance may include the provision of additional copies of résumés and cover letters when required, the identification of potential employers and job opportunities (and/or sources where these can be obtained) as well as ongoing job search support throughout the job search period.

Should (*client's name*) be successful in his/her efforts to secure paid substantially gainful employment within the _____ month job search period his/her disability benefits will be extended during a work trial for a minimum of three months. (*Client's name*) agrees to inform (*Service Provider's*) of all employment and employment-related earnings obtained during the job search and work trial period and agrees to provide copies of paystubs if requested by the Service Provider or Service Canada.

I agree to comply with the conditions outlined above and to take responsibility for carrying out my own job search to the best of my ability.

Client Signature:	**Date:**
Service Provider's Signature:	**Date:**

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "G" – REQUIRED CONTENT
EMPLOYER CONTACT SHEET

Client Name _____ **Identification Number:** _____

Date	Contact Type (phone, email, fax, In-person)	Company (Name & Address)	Contact Person (phone #)	Call Back	Apply In-Person	Submit Resume or Application	Job Interview or Info Interview	Outcome
		Name: Address:		Date: Time:	Date:	Date:	Date: Time: Contact:	
		Name: Address:		Date: Time:	Date:	Date:	Date: Time: Contact:	
		Name: Address:		Date: Time:	Date:	Date:	Date: Time: Contact:	
		Name: Address:		Date: Time:	Date:	Date:	Date: Time: Contact:	
		Name: Address:		Date: Time:	Date:	Date:	Date: Time: Contact:	

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "H" – REQUIRED CONTENT
RTW Follow-Up Report

Date of Report:	
Client Name:	**Service Provider(SP):**
Client Identifier Number:	**SP Consultant:**
Client Address:	**SP Consultant's Direct Telephone #:**
Client Phone #:	
Date(s) of contact(s) with the client:	
Date (s) of contact (s) with the employer:	
Service Canada VR Case Manager:	

EMPLOYMENT INFORMATION

Employer Name:	**Type of Work and Start Date:**
Employer Telephone # and Address:	**Nature of Employment:** ▪ Continuing/Permanent (full or part-time) ▪ Temporary (end date) ▪ Seasonal (end date) ▪ Self-Employment
Hour of Work (per day – week):	**Reason for Part-Time Employment (if applicable):** ▪ Client's Choice ▪ Labour Market Conditions ▪ Client's Work Capacity
Rate of Pay (per hour – week- month):	**Date & Reason Work Ceased (if applicable):**
Total Monthly Earnings:	

Supervisor Evaluation of Performance (complete only upon direction of Service Canada Vocational Rehabilitation Case Manager)

- Employer Accommodation
- Time loss due to illness (reasons)
- Job demand tolerance

Client Evaluation of Performance

- Employer Accommodation
- Time loss due to illness (reasons)
- Job demand tolerance

Service Provider Supports/Services: *(narrative of your support/services provided to the client during this time)*

Issues Identified:

Recommendations:

_____ _____

Consultant Signature Date

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "H" – REQUIRED CONTENT
RTW Follow-Up Report

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "I" – REQUIRED CONTENT
CLOSURE REPORT

Client Name:	**Service Provider (SP):**
Client Identifier Number:	**SP Consultant:**
Client Address:	**SP Consultant Direct Phone #:**
Client Phone #:	**Date of Report:**
Service Canada VR Case Manager:	

1. **Overview of Vocational Rehabilitation Activities and Outcomes:**
2. **Evidence of Client's Capacity or Incapacity to Return to Substantially Gainful Employment:**
3. **Where Substantially Gainful Employment is not achievable, provide any additional recommendation:**
4. **Total Invoiced Costs:**

_____ _____

Consultant Signature Date

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "J" – REQUESTED CONTENT
General Invoice Template

Invoice number	Invoice Date	Service Canada VRCM

Payment Information (please ensure that you have completed your Direct Deposit Information)

Service Provider Name:	Service Provider Branch Address:
Service Provider File Number:	Telephone Number (include area code)

Client Information

Client's Last Name	Client's First Name
Client Identification Number:	Procurement or Requisition Number:

Service Information

Date of service	Rehab Phase	Description	Number of hours	Cost per hour	Subtotal (not including taxes)	GST (if charged)	HST (if charged)	Total (including taxes)
								A:

Disbursement Information (at cost, no mark-up)

Date of service	Description	GST (if applicable)	HST (if applicable)	Total (including taxes – if applicable)
				B:
			Invoice Total A + B	

Canada Pension Plan Disability Vocational Rehabilitation Program
APPENDIX "K" – REQUESTED CONTENT
TRAVEL EXPENSE CLAIM

To Be Completed by the Traveller (Service Provider)

Organization: **Invoice #:**

Name: **Telephone:**

Address:

City: **Postal Code:**

START DATE OF TRAVEL: _____ **END DATE OF TRAVEL:** _____
DESTINATION: _____
TIME OF DEPARTURE: _____ **TIME OF RETURN:** _____
TOTAL DAYS TRAVELED FOR THIS INVOICE: _____

TRANSPORTATION		
Air fare as per ticket		$
Taxi, Bus, Train		$
Car: Rate/Km $ x Km travelled =		$
Other (specify)		$
	Subtotal	$
MEALS AND INCIDENTALS		
Breakfast (Leave residence before 6:30 a.m.)	$_____ X _____days	$
Lunch	$_____ X _____days	$
Dinner (Arrival at residence after 7:30 p.m.)	$_____ X _____days	$
Incidentals (For overnight stay only)	$_____ X _____days	$
	Subtotal	$
ACCOMMODATIONS		
Hotel / Motel	$_____ X _____days	$
Other (specify)_____	$_____ X _____days	$
	Subtotal	$
EXPENDITURES	**TOTAL**	$

Traveller's Signature:_____ **Date:**_____

This form must accompany the invoice and is subject to the Treasury Board Travel Policy. Receipts and Itemized invoice required for all travel except meals and incidentals.

Appendix L
Demonstrated Network for Specialized Assessments

(please use as many sheets as required to clearly demonstrate your network)

AREA:_____

Name/proposed company with address and telephone numbers:	Summary of Qualifications:	Services which they will be providing: Neuropsych Intelligence Achievement Job Demand Analysis Functional Capacity Ergonomic Psychovocational Job Modifications Work Samples Other: _____
Name/proposed company with address and telephone numbers:	Summary of Qualifications:	Services which they will be providing: Neuropsych Intelligence Achievement Job Demand Analysis Functional Capacity Ergonomic Psychovocational Job Modifications Work Samples Other: _____

Appendix M
SRCL

Government of Canada / Gouvernement du Canada

Contract Number / Numéro du contrat: G9292-190669
Security Classification / Classification de sécurité:

SECURITY REQUIREMENTS CHECK LIST (SRCL)
LISTE DE VÉRIFICATION DES EXIGENCES RELATIVES À LA SÉCURITÉ (LVERS)

PART A - CONTRACT INFORMATION / PARTIE A - INFORMATION CONTRACTUELLE

1. Originating Government Department or Organization / Ministère ou organisme gouvernemental d'origine: ESDC - SERVICE CANADA

2. Branch or Directorate / Direction générale ou Direction: Transformation and Integrated Service Management - CPR

3. a) Subcontract Number / Numéro du contrat de sous-traitance

3. b) Name and Address of Subcontractor / Nom et adresse du sous-traitant

4. Brief Description of Work / Brève description du travail
Initiation of a Request For Proposal process to establish contracts for the provision of Virtual and Retail Citizen Service to CPPD Beneficiaries residing in the Ontario region.

5. a) Will the supplier require access to Controlled Goods? / La fournisseur aura-t-il accès à des marchandises contrôlées? — No / Non ☑ Yes / Oui ☐

5. b) Will the supplier require access to unclassified military technical data subject to the provisions of the Technical Data Control Regulations? / La fournisseur aura-t-il accès à des données techniques militaires non classifiées qui sont assujetties aux dispositions du Règlement sur le contrôle de données techniques? — No / Non ☑ Yes / Oui ☐

6. Indicate the type of access required / Indiquer le type d'accès requis

6. a) Will the supplier and its employees require access to PROTECTED and/or CLASSIFIED information or assets? / Le fournisseur ainsi que les employés auront-ils accès à des renseignements ou à des biens PROTÉGÉS et/ou CLASSIFIÉS? — No / Non ☐ Yes / Oui ☑
(Specify the level of access using the chart in Question 7. c) / (Préciser le niveau d'accès en utilisant le tableau qui se trouve à la question 7. c)

6. b) Will the supplier and its employees (e.g. cleaners, maintenance personnel) require access to restricted access areas? No access to PROTECTED and/or CLASSIFIED information or assets is permitted. / Le fournisseur et ses employés (p. ex. nettoyeurs, personnel d'entretien) auront-ils accès à des zones d'accès restreintes? L'accès à des renseignements ou à des biens PROTÉGÉS et/ou CLASSIFIÉS n'est pas permis. — No / Non ☑ Yes / Oui ☐

6. c) Is this a electronic courier or delivery requirement with no overnight storage? / S'agit-il d'un contrat de messagerie ou de livraison commerciale sans entreposage de nuit? — No / Non ☑ Yes / Oui ☐

7. a) Indicate the type of information that the supplier will be required to access / Indiquer le type d'information auquel le fournisseur devra avoir accès

Canada ☑	NATO / OTAN ☐	Foreign / Étranger ☐

7. b) Release restrictions / Restrictions relatives à la diffusion

Canada	NATO / OTAN	Foreign / Étranger
No release restrictions / Aucune restriction relative à la diffusion ☑	All NATO countries / Tous les pays de l'OTAN ☐	No release restrictions / Aucune restriction relative à la diffusion ☐
Not releasable / À ne pas diffuser ☐		
Restricted to: / Limité à ☐	Restricted to / Limité à ☐	Restricted to: / Limité à ☐
Specify country(ies): / Préciser le(s) pays	Specify country(ies): / Préciser le(s) pays	Specify country(ies) / Préciser le(s) pays

7. c) Level of information / Niveau d'information

Canada	NATO / OTAN	Foreign / Étranger
PROTECTED A / PROTÉGÉ A ☐	NATO UNCLASSIFIED / NATO NON CLASSIFIÉ ☐	PROTECTED A / PROTÉGÉ A ☐
PROTECTED B / PROTÉGÉ B ☑	NATO RESTRICTED / NATO DIFFUSION RESTREINTE ☐	PROTECTED B / PROTÉGÉ B ☐
PROTECTED C / PROTÉGÉ C ☐	NATO CONFIDENTIAL / NATO CONFIDENTIEL ☐	PROTECTED C / PROTÉGÉ C ☐
CONFIDENTIAL / CONFIDENTIEL ☐	NATO SECRET / NATO SECRET ☐	CONFIDENTIAL / CONFIDENTIEL ☐
SECRET / SECRET ☐	COSMIC TOP SECRET / COSMIC TRÈS SECRET ☐	SECRET / SECRET ☐
TOP SECRET / TRÈS SECRET ☐		TOP SECRET / TRÈS SECRET ☐
TOP SECRET (SIGINT) / TRÈS SECRET (SIGINT) ☐		TOP SECRET (SIGINT) / TRÈS SECRET (SIGINT) ☐

TBS/SCT 350-103(2004/12)

Security Classification / Classification de sécurité

Canada

Government of Canada / Gouvernement du Canada

Contract Number / Numéro du contrat: 69292-190669

Security Classification / Classification de sécurité

PART A (TO BE COMPLETED BY AUTHORITY)

9. Will the supplier require access to PROTECTED and/or CLASSIFIED COMSEC information or assets? / Le fournisseur aura-t-il accès à des renseignements ou à des biens COMSEC désignés PROTÉGÉS et/ou CLASSIFIÉS? — [✓] No / Non [ ] Yes / Oui

If Yes, indicate the level of sensitivity / Dans l'affirmative, indiquer le niveau de sensibilité

9. Will the supplier require access to extremely sensitive INFOSEC information or assets? / Le fournisseur aura-t-il accès à des renseignements ou à des biens INFOSEC de nature extrêmement délicate? — [✓] No / Non [ ] Yes / Oui

Short Title(s) of material / Titre(s) abrégé(s) du matériel:

Document Number / Numéro du document:

PART B (TO BE COMPLETED BY AUTHORITY) / PARTIE B (À REMPLIR PAR L'AUTORITÉ)

10. a) Personnel security screening level required / Niveau de contrôle de la sécurité du personnel requis

- [✓] RELIABILITY STATUS / COTE DE FIABILITÉ
- [ ] CONFIDENTIAL / CONFIDENTIEL
- [ ] SECRET / SECRET
- [ ] TOP SECRET / TRÈS SECRET
- [ ] TOP SECRET – SIGINT / TRÈS SECRET – SIGINT
- [ ] NATO CONFIDENTIAL / NATO CONFIDENTIEL
- [ ] NATO SECRET / NATO SECRET
- [ ] COSMIC TOP SECRET / COSMIC TRÈS SECRET
- [ ] SITE ACCESS / ACCÈS AUX EMPLACEMENTS

Special comments: / Commentaires spéciaux :

NOTE: If multiple levels of screening are identified, a Security Classification Guide must be provided. / REMARQUE : Si plusieurs niveaux de contrôle de sécurité sont requis, un guide de classification de la sécurité doit être fourni.

10. b) May unscreened personnel be used for portions of the work? / Du personnel sans autorisation sécuritaire peut-il se voir confier des parties du travail? — [✓] No / Non [ ] Yes / Oui

If Yes, will unscreened personnel be escorted? / Dans l'affirmative, le personnel en question sera-t-il escorté? — [ ] No / Non [ ] Yes / Oui

PART C (A) (TO BE COMPLETED BY AUTHORITY IF ANSWER TO QUESTION 9 IS YES) / PARTIE C (A) (À REMPLIR PAR L'AUTORITÉ SI LA RÉPONSE À LA QUESTION 9 EST OUI)

INFORMATION / ASSETS / RENSEIGNEMENTS / BIENS

11. a) Will the supplier be required to receive and store PROTECTED and/or CLASSIFIED information or assets on its site or premises? / Le fournisseur sera-t-il tenu de recevoir et d'entreposer sur place des renseignements ou des biens PROTÉGÉS et/ou CLASSIFIÉS? — [ ] No / Non [✓] Yes / Oui

11. b) Will the supplier be required to safeguard COMSEC information or assets? / Le fournisseur sera-t-il tenu de protéger des renseignements ou des biens COMSEC? — [✓] No / Non [ ] Yes / Oui

PRODUCTION

11. c) Will the production (manufacture, and/or repair and/or modification) of PROTECTED and/or CLASSIFIED material or equipment occur at the supplier's site or premises? / Les installations du fournisseur serviront-elles à la production (fabrication et/ou réparation et/ou modification) de matériel PROTÉGÉ et/ou CLASSIFIÉ? — [✓] No / Non [ ] Yes / Oui

INFORMATION TECHNOLOGY (IT) MEDIA / SUPPORT RELATIF À LA TECHNOLOGIE DE L'INFORMATION (TI)

11. d) Will the supplier be required to use its IT systems to electronically process, produce or store PROTECTED and/or CLASSIFIED information or data? / Le fournisseur sera-t-il tenu d'utiliser ses propres systèmes informatiques pour traiter, produire ou stocker électroniquement des renseignements ou des données PROTÉGÉS et/ou CLASSIFIÉS? — [ ] No / Non [✓] Yes / Oui

11. e) Will there be an electronic link between the supplier's IT systems and the government department or agency? / Disposera-t-on d'un lien électronique entre le système informatique du fournisseur et celui du ministère ou de l'agence gouvernementale? — [✓] No / Non [ ] Yes / Oui

TBS/SCT 350-103(2004/12)

Security Classification / Classification de sécurité

Canada

Government of Canada / Gouvernement du Canada

Contract Number / Numéro du contrat
G9292-190669
Security Classification / Classification de sécurité

PART C - SAFEGUARDS (IF APPLICABLE)

For users completing the form manually use the summary chart below to indicate the category(ies) and level(s) of safeguarding required at the supplier's site(s) or premises.
Les utilisateurs qui remplissent le formulaire manuellement doivent utiliser le tableau récapitulatif ci-dessous pour indiquer, pour chaque catégorie, les niveaux de sauvegarde requis aux installations du fournisseur.

For users completing the form online (via the Internet), the summary chart is automatically populated by your responses to previous questions.
Dans le cas des utilisateurs qui remplissent le formulaire en ligne (par Internet), les réponses aux questions précédentes sont automatiquement saisies dans le tableau récapitulatif.

SUMMARY CHART / TABLEAU RÉCAPITULATIF

Category / Catégorie	PROTECTED / PROTÉGÉ			CLASSIFIED / CLASSIFIÉ			NATO				COMSEC					
	A	B	C	CONFIDENTIAL / CONFIDENTIEL	SECRET	TOP SECRET / TRÈS SECRET	NATO RESTRICTED / NATO DIFFUSION RESTREINTE	NATO CONFIDENTIAL / NATO CONFIDENTIEL	NATO SECRET	COSMIC TOP SECRET / COSMIC TRÈS SECRET	PROTECTED / PROTÉGÉ A	PROTECTED / PROTÉGÉ B	PROTECTED / PROTÉGÉ C	CONFIDENTIAL / CONFIDENTIEL	SECRET	TOP SECRET / TRÈS SECRET
		✓														
		✓														

12. a) Is the description of the work contained within this SRCL PROTECTED and/or CLASSIFIED?
La description du travail visé par la présente LVERS est-elle de nature PROTÉGÉE et/ou CLASSIFIÉE?
☑ No / Non ☐ Yes / Oui

If Yes, classify this form by annotating the top and bottom in the area entitled "Security Classification".
Dans l'affirmative, classifier le présent formulaire en indiquant le niveau de sécurité dans la case intitulée « Classification de sécurité » au haut et au bas du formulaire.

12. b) Will the documentation attached to this SRCL be PROTECTED and/or CLASSIFIED?
La documentation associée à la présente LVERS sera-t-elle PROTÉGÉE et/ou CLASSIFIÉE?
☑ No / Non ☐ Yes / Oui

If Yes, classify this form by annotating the top and bottom in the area entitled "Security Classification" and indicate with attachments (e.g. SECRET with Attachments).
Dans l'affirmative, classifier le présent formulaire en indiquant le niveau de sécurité dans la case intitulée « Classification de sécurité » au haut et au bas du formulaire et indiquer qu'il y a des pièces jointes (p. ex. SECRET avec des pièces jointes).

Government of Canada / Gouvernement du Canada

Contract Number / Numéro du contrat
G9292-190669
Security Classification / Classification de sécurité

PART C - AUTHORIZATION / PARTIE C - AUTORISATION

13. Organization Project Authority / Chargé de projet de l'organisme

Name (print) - Nom (en lettres moulées)	Title - Titre	Signature
Nathalie Chalifoux	Director - CPP Operations	Nathalie Chalifoux

Telephone No. - N° de téléphone	Facsimile No. - N° de télécopieur	E-mail address - Adresse courriel	Date
819-654-7260	613-857-7171	nathalie.chalifoux@servicecanada.gc.ca	

14. Organization Security Authority / Responsable de la sécurité de l'organisme

Name (print) - Nom (en lettres moulées)	Title - Titre	Signature
RICHARD LAHAIE (David Zare)	MANAGER Manager Security Operations	Richard Lahaie

Telephone No. - N° de téléphone	Facsimile No. - N° de télécopieur	E-mail address - Adresse courriel	Date
819-654-4363	819-953-7001	david.zare@servicecanada.gc.ca	2018-03-26

15. Are there additional instructions (e.g. Security Guide, Security Classification Guide) attached?
Des instructions supplémentaires (p. ex. Guide de sécurité, Guide de classification de la sécurité) sont-elles jointes? ☑ No Non ☐ Yes Oui

16. Procurement Officer / Agent d'approvisionnement

Name (print) - Nom (en lettres moulées)	Title - Titre	Signature
Janice Baird	Supply Specialist	Janice Baird

Telephone No. - N° de téléphone	Facsimile No. - N° de télécopieur	E-mail address - Adresse courriel	Date
709-772-2999	709-772-4603	janice.baird@tpsgc-pwgsc.gc.ca	March 14, 2018

17. Contracting Security Authority / Autorité contractante en matière de sécurité

Name (print) - Nom (en lettres moulées)	Title - Titre	Signature

Telephone No. - N° de téléphone	Facsimile No. - N° de télécopieur	E-mail address - Adresse courriel	Date

TBS/SCT 350-103(2004/12)

Security Classification / Classification de sécurité

Canada