



Please refer to the guide when completing this application form. The guide contains useful information and assistance for completing this form. Please type your answers or print them in ink in legible handwriting.

We may award compensation only if you were injured in the Province of Ontario as a result of a violent crime, or while making an arrest or assisting a peace officer with his/her law enforcement duties, or while trying to prevent a crime.

Please refer to the guide for more information about who is eligible for compensation.

Please provide all of the requested information in order to ensure that your application is processed as quickly as possible. Our contact centre is available to assist you should you have any questions not answered in the guide. Please read the form carefully so you complete only the sections that apply to you.

Send your completed application form to the Board with as much supporting documentation as possible. If you have a restraining order, peace bond, probation order, police records (occurrence report, crown synopsis, record of arrest), Court records (Information/Indictment), victim impact statement, power of attorney, medical or therapy records that support your injuries, invoices and/or original receipts, include these documents with your application. If you do not have these documents, do not wait to mail the application form to the Board. Gather the documents and then mail them to the Board once they become available.

Please only send the Board copies of supporting documents. Do not send original documents.

If there is not enough space in certain parts of the application form, use Part 12, Additional Information section. Remember to include your name on completed attachments and specify the section of the application form the additional information pertains to.

It is important that we receive your application form within two years of the crime taking place. We can extend the two-year limitation when it is warranted, but you will have to request such an extension and explain your reason(s) for the delay in Part 5 of the application. Note: If this application is as a result of a crime of sexual violence or of violence that occurred within a relationship of intimacy or dependency the two year limitation period does not apply.

It is essential that you let us know whenever your address or phone number changes. If we are unable to reach you by phone or mail, your application may be dismissed.

Mail, fax or email your completed application form and supporting documents to the addresses or numbers noted below. For more information about the Criminal Injuries Compensation Board and the application process, please visit our website. Website: www.sjto.gov.on.ca/cicb

Criminal Injuries Compensation Board
655 Bay Street, 14th Floor
Toronto ON M7A 2A3
Tel: 416 326-2900 (within the Greater Toronto Area)
Toll Free: 1 800 372-7463
Fax: 416 326-2883, Toll Free: 1 844 249-1619
Email: info.cicb@ontario.ca

The Victim Support Line (VSL), through FindHelp, provides a province-wide, toll-free telephone information line providing access to information for victims, in the language of their choice, 24 hours a day, seven days a week. If you would like to find out about services in your area, or would like to inquire about organizations that might be willing to assist with the completion of your application, call the Victim Support Line at 1 888 579-2888 (if you live in the Greater Toronto Area, call 416 314-2447) and choose option 1.

**Please type your answers or print them in ink in legible handwriting.
A separate application must be filed for each person seeking compensation.**

Part 1: Victim Information

The victim is the person who was injured during the crime. A date of birth is needed to avoid confusion with other victims with the same or similar names. As we may need to contact you during business hours, a daytime number would be helpful. If you are filing this application on behalf of someone else, put his/her information in Part 1 and your information in Part 2.

Last Name			First Name			Middle Initial		
Last Name at Birth			Date of Birth (yyyy/mm/dd)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans <input type="checkbox"/> Other, please specify:		
Unit No.	Street No.	Street Name				PO Box	Postal Code	
City/Town				Province		Home Telephone No.		
Email Address				Driver's Licence Number		Alternate Telephone No.		

Do you have any concerns with the Board leaving messages regarding this claim at either of the above phone numbers?

No Yes - (if so please explain)

What is your preferred method of communication with the Board? (if you check email, you are consenting to the delivery of personal information and documents by email) Mail Email Telephone

Will you require an interpreter at a hearing?

No Yes (specify a language)

Have you filed an application with the Board before?

No Yes (specify the year)

Would you like to permit someone else to speak with the Board on your behalf? If so, provide name.

Name (first and last)

Telephone No.

Is the Board authorized to release reports to the individual named?

Yes No

Is the named individual authorized to update your contact information with the Board?

Yes No

Is the named individual authorized to request duplicate letters from the Board?

Yes No

Part 2: Applicant Information (if applicable)

Complete this part only if you are not the crime victim, but you are acting on his/her behalf.

You may be the applicant for a crime victim if:

- you are a parent or legal guardian of a victim who is a minor (under the age of 18); or
- you have the legal authority to make decisions for a victim because he/she cannot make decisions for himself/herself (e.g. due to mental/physical incapacity). Please provide a copy of the power of attorney.

If you are filing this application as a result of witnessing an extremely violent crime against a close family member, put his/her information in Part 1 and your information in Part 2.

Last Name			First Name			Middle Initial		
Your Relationship to the Victim			Date of Birth (yyyy/mm/dd)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans <input type="checkbox"/> Other, please specify:		
Name of Organization (if applicable)								
Unit No.	Street No.	Street Name				PO Box	Postal Code	
City/Town				Province		Home Telephone No.		
Email Address				Driver's Licence Number		Alternate Telephone No.		

Do you have any concerns with the Board leaving messages regarding this claim at either of the above phone numbers?

No Yes - (if so please explain)

Will you require an interpreter at a hearing?

No Yes (specify a language)

What is your preferred method of communication with the Board? (if you check email, you are consenting to the delivery of personal information and documents by email) Mail Email Telephone

Warning: While we have a variety of security measures in place, it is important to remember that email is not secure. We cannot guarantee the privacy or confidentiality of any information that is sent over the Internet by email as it may not be free from interception by third parties.

Part 3: Legal Representation (for the purpose of this application only)

Complete this part only if you have retained a lawyer, agent or paralegal to assist you with your claim for compensation. If you have retained legal representation for another purpose, such as a criminal or civil proceeding, do not complete this part. **By completing this part, you are authorizing the Board to release information about your claim to your legal representative and all further communication will be made with your legal representative.**

Legal Representative's Last Name			Legal Representative's First Name		
Name of Law Firm/Legal Clinic					
Unit No.	Street No.	Street Name		PO Box	Rural Route
City/Town			Province	Postal Code	Country
Telephone No.		Fax No.	Email Address		

Part 4: Types of Compensation

This part must be completed to let us know the type of compensation you are seeking. We may award compensation only if you were injured in the Province of Ontario as a result of a violent crime, or while making an arrest or assisting a peace officer with his/her law enforcement duties, or while trying to prevent a crime.

Please check the appropriate box(es)

- | | |
|---|---|
| <input type="checkbox"/> Medical expenses | <input type="checkbox"/> Pain and suffering award |
| <input type="checkbox"/> Treatment expenses | <input type="checkbox"/> Loss of wages/income |
| <input type="checkbox"/> Dental expenses | <input type="checkbox"/> Support of a child born as a result of a sexual assault (rape) |
| <input type="checkbox"/> Travel to treatment expenses | <input type="checkbox"/> Other expenses/financial losses (please specify): |

Part 5: Request for Extension Where Crime Occurred More than Two Years Ago

If you are applying for compensation for an incident that occurred more than two years ago, you must first request that we extend the two-year limitation period. Please check "Yes" and explain your reason(s) for the delay in filing this application. Be sure to complete the rest of the application form. If this application relates to a victim who is under the age of 20, an extension of the limitation period for filing is not required. If this application is as a result of a crime of sexual violence or of violence that occurred within a relationship of intimacy or dependency the two year limitation period does not apply. In those cases, please check "No" and proceed to Part 6 of the application. The Board will render its decision on the extension based on written information you provide including the information you have given in the application form.

Was the crime committed more than two years ago? (In the case of ongoing abuse, did the abuse end more than two years ago?)

- No - Proceed to Part 6
- Yes - Please explain below why you did not submit your application within two years of the crime(s) being committed

Section A: Complete this section if the incident was reported to the police.

Date the incident was reported to the police (yyyy/mm/dd)	Name of Police Service(s) and Division Number	Name of Police Officer(s) and Badge Number(s)	Occurrence Number

Were charges laid by the police?

- No Don't Know Yes - if Yes, what were those charges?

Do you know the outcome of those charges?

- No Yes - if Yes, please indicate Conviction Withdrawn
 Acquittal Absolute/Conditional Discharge

Is the police investigation or criminal proceeding ongoing?

- No Yes

If there was a delay in reporting the incident to the police, please explain the reason for the delay:

Did you participate in the police investigation?

- Yes No - Explain why:

Did you attend criminal court when required to do so? (e.g. if you were served with a summons)

- Yes No - Explain why:

Section B: Complete this section if the incident was not reported to the police

What were your reasons for not reporting the incident to the police:

If the incident occurred when you were a child, was it reported to a Children's Aid Society?

- No Yes - Provide details:

Part 6 (B): Multiple Incidents / Patterns of Abuse

Complete this section only if you were injured as a result of multiple crimes/ incidents (e.g. abused/assaulted repeatedly over weeks, months or years).

If you were abused by multiple individuals or multiple times by the same individual, please complete the following sections for each of the (alleged) offenders. If there were more than three (alleged) offenders, please contact us at 416 326-2900 or 1 800 372-7463 for additional forms.

Information for (Alleged) Offender Number 1

Name of (Alleged) Offender Number 1 (first and last name)		Date of Birth (yyyy/mm/dd)	Address	Relationship to Victim (e.g. stranger, friend, spouse, etc.)
Date of incident (if only one) (yyyy/mm/dd)	Or, if more than one incident, provide dates ►	Date when abuse began (yyyy/mm/dd)		Date when abuse ended (yyyy/mm/dd)
Where did the incident/abuse occur? (e.g. home, on the street, school, etc.)	Provide specific address where the incident/abuse occurred (Note: it must have occurred in Ontario to be eligible for compensation)			
	Street Address	City/Town	Province	

Details of the Crime:

In the space below, please describe what happened in your own words. If you require additional space, please use the **Additional Information Section (Part 12)**.

Section A: Complete this section if the incident(s) involving (Alleged) Offender No. 1 was reported to the police.

Date the incident / abuse was reported to the police (yyyy/mm/dd)	Name of Police Service(s) and Division Number	Name of Police Officer(s) and Badge Number(s)	Occurrence Number

Were charges laid by the police?

No Don't Know Yes - if Yes, what were those charges?

Do you know the outcome of those charges?

No Yes - if Yes, please indicate Conviction Withdrawn
 Acquittal Absolute/Conditional Discharge

Is the police investigation or criminal proceeding ongoing?

No Yes

If there was a delay in reporting the incident/abuse to the police, please explain the reason for the delay:

Did you participate in the police investigation?
 Yes No - Explain why:

Did you attend criminal court when required to do so? (e.g. if you were served with a summons)

Yes No - Explain why:

Section B: Complete this section if the incident(s) involving (Alleged) Offender No. 1 was not reported to the police.

What were your reasons for not reporting the incident/abuse to the police:

If the incident/abuse occurred when you were a child, was it reported to a Children's Aid Society?
 No Yes - Provide details:

Information for (Alleged) Offender Number 2

Name of (Alleged) Offender Number 2 (first and last name)		Date of Birth (yyyy/mm/dd)	Address	Relationship to Victim (e.g. stranger, friend, spouse, etc.)
Date of incident (if only one) (yyyy/mm/dd)		Or, if more than one incident, provide dates ►	Date when abuse began (yyyy/mm/dd)	Date when abuse ended (yyyy/mm/dd)
Where did the incident/abuse occur? (e.g. home, on the street, school, etc).			Provide specific address where the incident/abuse occurred (Note: it must have occurred in Ontario to be eligible for compensation) Street Address City/Town Province	

Details of the Crime:

In the space below, please describe what happened in your own words. If you require additional space, please use the **Additional Information Section (Part 12)**.

Section A: Complete this section if the incident(s) involving (Alleged) Offender No. 2 was reported to the police.

Date the incident / abuse was reported to the police (yyyy/mm/dd)	Name of Police Service(s) and Division Number	Name of Police Officer(s) and Badge Number(s)	Occurrence Number

Were charges laid by the police?
 No Don't Know Yes - if Yes, what were those charges?

Do you know the outcome of those charges?
 No Yes - if Yes, please indicate Conviction Withdrawn
 Acquittal Absolute/Conditional Discharge

Is the police investigation or criminal proceeding ongoing?
 No Yes

If there was a delay in reporting the incident/abuse to the police, please explain the reason for the delay:

Did you participate in the police investigation?
 Yes No - Explain why:

Did you attend criminal court when required to do so? (e.g. if you were served with a summons)
 Yes No - Explain why:

Section B: Complete this section if the incident(s) involving (Alleged) Offender No. 2 was not reported to the police.

What were your reasons for not reporting the incident/abuse to the police:

If the incident/abuse occurred when you were a child, was it reported to a Children's Aid Society?
 No Yes - Provide details:

Information for (Alleged) Offender Number 3

Name of (Alleged) Offender Number 3 (first and last name)	Date of Birth (yyyy/mm/dd)	Address	Relationship to Victim (e.g. stranger, friend, spouse, etc.)
Date of incident (if only one) (yyyy/mm/dd)	Or, if more than one incident, provide dates ►	Date when abuse began (yyyy/mm/dd)	Date when abuse ended (yyyy/mm/dd)
Where did the incident/abuse occur? (e.g. home, on the street, school, etc).	Provide specific address where the incident/abuse occurred (Note: it must have occurred in Ontario to be eligible for compensation)		
	Street Address	City/Town	Province

Details of the Crime:

In the space below, please describe what happened in your own words. If you require additional space, please use the **Additional Information Section (Part 12)**.

Section A: Complete this section if the incident(s) involving (Alleged) Offender No. 3 was reported to the police.

Date the incident / abuse was reported to the police (yyyy/mm/dd)	Name of Police Service(s) and Division Number	Name of Police Officer(s) and Badge Number(s)	Occurrence Number

Were charges laid by the police?

No Don't Know Yes - if Yes, what were those charges?

Do you know the outcome of those charges?

No Yes - if Yes, please indicate Conviction Withdrawn
 Acquittal Absolute/Conditional Discharge

Is the police investigation or criminal proceeding ongoing?

No Yes

If there was a delay in reporting the incident/abuse to the police, please explain the reason for the delay:

Did you participate in the police investigation?
 Yes No - Explain why:

Did you attend criminal court when required to do so? (e.g. if you were served with a summons)
 Yes No - Explain why:

Section B: Complete this section if the incident(s) involving (Alleged) Offender No. 3 was not reported to the police.

What were your reasons for not reporting the incident/abuse to the police:

If the incident/abuse occurred when you were a child, was it reported to a Children's Aid Society?
 No Yes - Provide details:

If there were more than three (alleged) offenders, please contact us at 416 326-2900 or 1 800 372-7463 for additional forms.

Part 8: Medical and / or Treatment Information

Please list the names, addresses and phone numbers of the professionals who treated you as a direct result of your injuries that resulted from the crime(s). This means people like doctors, dentists, hospital or clinic staff, counsellors, therapists and others.

Emergency Treatment

Hospital / Clinic Name	Telephone No.	Treatment Date(s) ▶	From (yyyy/mm/dd)	To (yyyy/mm/dd)
Address (Street No., Street Name, City, Province)				

Other Hospital / Clinic Treatment

Hospital / Clinic Name	Telephone No.	Treatment Date(s) ▶	From (yyyy/mm/dd)	To (yyyy/mm/dd)
Address (Street No., Street Name, City, Province)				

Medical Doctor / Health Practitioner

Name of Primary Doctor / Practitioner		Name of Practice/Clinic		Telephone No.	
Unit No.	Street No.	Street Name		PO Box	Rural Route
City/Town			Province	Postal Code	Country
Estimated number of visits			Treatment Date(s) ▶	From (yyyy/mm/dd)	To (yyyy/mm/dd)

Medical Doctor / Health Practitioner

Name of Other Doctor / Practitioner		Name of Practice/Clinic		Telephone No.	
Unit No.	Street No.	Street Name		PO Box	Rural Route
City/Town			Province	Postal Code	Country
Estimated number of visits			Treatment Date(s) ▶	From (yyyy/mm/dd)	To (yyyy/mm/dd)

Psychiatrist/Psychologist/Counsellor/Therapist

Name of Primary Treatment Provider		Name of Practice/Clinic		Telephone No.	
Unit No.	Street No.	Street Name		PO Box	Rural Route
City/Town			Province	Postal Code	Country
Estimated number of visits			Treatment Date(s) ▶	From (yyyy/mm/dd)	To (yyyy/mm/dd)

Psychiatrist/Psychologist/Counsellor/Therapist

Name of Other Treatment Provider		Name of Practice/Clinic		Telephone No.	
Unit No.	Street No.	Street Name		PO Box	Rural Route
City/Town			Province	Postal Code	Country
Estimated number of visits			Treatment Date(s) ▶	From (yyyy/mm/dd)	To (yyyy/mm/dd)

Dentist / Dental Specialist

Name of Dentist / Dental Specialist		Name of Practice/Clinic		Telephone No.	
Unit No.	Street No.	Street Name		PO Box	Rural Route
City/Town			Province	Postal Code	Country
Estimated number of visits			Treatment Date(s) ▶	From (yyyy/mm/dd)	To (yyyy/mm/dd)

Dentist / Dental Specialist

Name of Other Dentist / Dental Specialist		Name of Practice/Clinic		Telephone No.	
Unit No.	Street No.	Street Name		PO Box	Rural Route
City/Town			Province	Postal Code	Country
Estimated number of visits			Treatment Date(s) ▶	From (yyyy/mm/dd)	To (yyyy/mm/dd)

Any Other Treatment Provider

Name of Treatment Provider		Name of Practice/Clinic		Telephone No.	
Unit No.	Street No.	Street Name		PO Box	Rural Route
City/Town			Province	Postal Code	Country
Estimated number of visits	Type of Treatment		Treatment Date(s) ▶	From (yyyy/mm/dd)	To (yyyy/mm/dd)

Any Other Treatment Provider

Name of Other Treatment Provider		Name of Practice/Clinic		Telephone No.	
Unit No.	Street No.	Street Name		PO Box	Rural Route
City/Town			Province	Postal Code	Country
Estimated number of visits	Type of Treatment		Treatment Date(s) ▶	From (yyyy/mm/dd)	To (yyyy/mm/dd)

Treatment for Multiple Injuries

If you are filing this application for several injuries involving multiple (alleged) offenders, specify the type of treatment received for each injury (if you are able to do so).

Part 9: Compensation from Other Sources

Have you received (or will you receive) compensation from any other source in respect of this injury?

No Yes - Provide details, specify amount and whether it has been paid:

Have you received any services through the Victim Quick Response Program (VQRP) in respect of this injury?

No Yes - Provide details:

If the crime occurred at work and you filed a claim with the Workplace Safety and Insurance Board (WSIB), did you (or will you) receive a non-economic loss award?

No Yes - Specify amount and whether it has been paid:

Has the court ordered the (Alleged) Offender to pay restitution to you?

No Yes - Specify amount and whether it has been paid:

Have you commenced a civil court action against the (alleged) offender?

No - Advise whether you intend to do so in the future?

Yes - Provide the following information below:

Court File No.	Court Location	Amount awarded in civil action \$	Amount you have already received \$

Part 10: Expense Information (if applicable)

Please check all of the expenses that are presently known and any you think you might have in the future. If you do not know the exact cost, tell us how much you think you paid in the "Amount" column shown below.

Are you claiming any expenses as a result of your injury?

No - Proceed to Part 11 Yes - Provide details below:

Please check all boxes that apply	Amount	Has this amount been paid?	Who paid the expense?	Please check if you are attaching original invoices/receipts
<input type="checkbox"/> Ambulance	\$	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Hospital	\$	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Dental	\$	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Physio/Chiro/Massage	\$	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Prescription drugs	\$	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Counselling/therapy	\$	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Prosthetic devices	\$	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Other (please specify): ▶	\$	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Travel to treatment (if more than 40 km each way from your residence)	From (city/town)	To (city/town)	No. of kms travelled roundtrip	
	From (city/town)	To (city/town)	No. of Trips:	
	From (city/town)	To (city/town)	No. of kms travelled roundtrip	
			No. of Trips:	

Are any of the claimed expenses covered through other sources? (e.g. WSIB, ODSP, private insurance, etc.)

No - Proceed to Part 11 Yes - Provide details below:

Part 11: Loss of Income (if applicable)

Did the crime occur at work? No Yes

If the crime occurred at work, did you file a claim with the Workplace Safety and Insurance Board (WSIB)?

No Yes - Provide WSIB claim number:

Name of Adjudicator:

Are you claiming a loss of wages/income?

No - Proceed to Part 12 Yes - as a result of my injury (provide details below)

Yes - as a result of caring for an injured victim (provide details below)

If you are claiming loss of wages/income and you worked for more than one employer, please use the Additional Information section (Part 12) to provide us with details regarding any additional employer(s).

Were you employed when the crime occurred? <input type="checkbox"/> No <input type="checkbox"/> Yes		Were you self employed? <input type="checkbox"/> No <input type="checkbox"/> Yes		Occupation	
Name of Company / Employer			Contact Person		Telephone No.
Unit No.	Street No.	Street Name		PO Box	Rural Route
City/Town			Province	Postal Code	Country
Did your injury cause you to miss work? <input type="checkbox"/> No <input type="checkbox"/> Yes - Specify dates ►		Start Date (yyyy/mm/dd)	End Date (yyyy/mm/dd)	Specify amount of lost income (net) \$	

Are you unable to return to work as a result of your injury? No Yes

Did you, or will you, receive any of the following due to your injury or while you are caring for an injured person?

No Yes - Provide the following information below:

Please check all boxes that apply	Start Date (yyyy/mm/dd)	End Date (yyyy/mm/dd)	Amount you have received (or will receive)
<input type="checkbox"/> Employment Insurance benefits			\$
<input type="checkbox"/> Canada Pension Plan disability benefits			\$
<input type="checkbox"/> Workplace Safety and Insurance Board benefits			\$
<input type="checkbox"/> Indian Northern Affairs benefits			\$
<input type="checkbox"/> Private Insurance disability benefits Provide name of Insurance Company: ►			\$
<input type="checkbox"/> Other (please specify): ►			\$

If you are seeking compensation for loss of wages/income as a result of caring for an injured victim, please provide us with your full name, address and telephone number along with details regarding the type of care you are providing below.

Last Name			First Name		
Unit No.	Street No.	Street Name		PO Box	Rural Route
City/Town			Province	Postal Code	Telephone No.

Details:

Part 13: Agreement and Authorization for Release of Information

Please read this part carefully. There are certain conditions that apply when a person makes an application for and receives compensation. It is important that you are aware of these conditions. Your signature below shows that you have read, understood and agreed to what is listed below.

1. For the purpose of this application, **I The Undersigned**, hereby consent and authorize:
 - all hospitals, treatment facilities, health and medical practitioners from whom I received treatment, or that will be providing future treatment, to provide the Board at its request with information as to my injuries and treatment;
 - the Police to provide the Board at its request with relevant information;
 - correctional facilities, law enforcement and security agencies for public and private institutions/organizations to provide the Board at its request with relevant information;
 - the Workplace Safety and Insurance Board, Canada Employment Insurance Commission, Canada Revenue Agency, Canada Pension Plan and/or any other authority from which I may receive payments from Provincial or Federal funds to provide the Board at its request with relevant information;
 - my employer(s), my union, Canada Revenue Agency and any other authority to provide the Board at its request with information as to my earnings, income, and any benefits received or receivable;
 - all accident, sickness, or life insurance companies, or private pension schemes from which I have received or will receive payments, or other benefits, to provide the Board at its request with relevant information;
 - the Victim Quick Response Program to provide the Board with information regarding services reimbursed through its program.
2. **I Understand that:** (a) the Board may notify the authorities mentioned above that I have submitted an application and may also inform them of the Board's decision; (b) any information submitted to the Board is subject to the *Freedom of Information and Protection of Privacy Act* and the *Statutory Powers Procedure Act*; (c) it is my responsibility to inform the Board of any change in my address and that my claim may be dismissed following a period of time if the Board is unable to contact me; (d) my failure to cooperate with law enforcement (police, Crown, criminal court) may result in the denial of my claim; (e) if my behaviour contributed directly or indirectly to my injuries, this may result in the denial of my claim or affect the amount of compensation I receive; (f) payment by the Board is a payment of last resort and as such, I hereby agree, within a reasonable time period, to notify the Board in the event that benefits and/or other funds become available to me as compensation for this injury or death.
3. **I Agree to:** (a) give the Board all necessary assistance with respect to the above-noted matters; (b) notify the Board of any change in circumstances that may affect the assessment of my compensation; (c) repay the Board if payments are received from the (alleged) offender (restitution or civil action), insurance, WSIB, or any other government or private agency as compensation for this injury after receipt of payment from the Board.

4. **I Certify that:** all the above statements contained in my application are true to the best of my knowledge and belief.

If you have any questions, please contact this office at 416 326-2900 or toll free at 1 800 372-7463 or visit our website at www.sjto.gov.on.ca/cicb for additional information.

The personal information on this form is collected under the authority of the *Compensation for Victims of Crime Act*, R.S.O. 1990, c.C.24. The principle purpose for which this information will be used is to make a determination of eligibility for an amount of compensation. Please be advised that any information submitted to the Board is subject to the *Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. F.31 and the *Statutory Powers Procedure Act*, R.S.O. 1990, c. S.22. Any questions regarding the collection of personal information should be directed to the Freedom of Information Coordinator, at the Criminal Injuries Compensation Board, 655 Bay Street, 14th Floor, Toronto, ON M7A 2A3, Telephone: 416 326-2900 or Toll Free: 1 800 372-7463.

Submission Options: Choose one of the following options to submit this form

Option 1 - Email

By checking this box and typing my name below, I certify that all information on this form is true and correct. I also agree that the checkbox and my name typed below are to be used as my electronic signature.

Last Name

First Name

Middle Initial

Option 2 - Fax/Mail - If you are submitting the completed form by fax or mail, please sign and date below.

Signature

Date (yyyy/mm/dd)

X