IVAC
Indemnisation des victimes d'actes criminels

ATTESTATION FORM OF A SERVICE PROVIDER OR PROFESSIONAL

Document in support of an application for qualification or financial assistance to contribute to the needs of a child who was born as a result of a sexual assault

1. **Enter the information requested in the appropriate fields.**

2. **Send the completed document to the Directon générale de l'IVAC:**

Online	By mail	By fax
www.ivac.qc.ca	1600, avenue d'Estimauville, CP 1400 Succ. Terminus Québec (Québec) G1K 0K2	1 888 927-0003

1. IDENTIFICATION *(to be completed by the person who submits the application)*

Surname	First name	Date of birth	Health insurance no. or social insurance no.
		Y Y Y Y M M D D	

Address	Telephone	IVAC file no. *(if known)*

2. ATTESTATION OF THE SERVICE PROVIDER OR PROFESSIONAL *(to be completed by the service provider or professional)*

Surname	First name	Telephone

Profession/Occupation	Employer

If necessary, use the additional space at the end of the form.

I certify that I spoke with the person identified in Section 1 for a consultation related to:

- the following offence (s): _____
  (describe the criminal offence(s) reported by the person)
- which occurred on or about _____ *(date or period)*
- in _____ *(city/country)* _____.

This person identified themselves as:

- ☐ The person who was the victim of the criminal offence.
- ☐ The parent, child, dependant, spouse or a relative of the person who was the victim of the criminal offence.
- ☐ A witness to the criminal offence.
- ☐ The person who intervened to prevent a criminal offence or to arrest the perpetrator.
- ☐ The parent, child, dependant, spouse or a relative of the person who intervened to prevent a criminal offence or to arrest the perpetrator.
- ☐ The person who provides for the needs of a child who was born as a result of a sexual assault

▶ Signature of the service provider or professional	Date
	Y Y Y Y M M D D

Additional information