EMPLOYMENT/EDUCATION DIARY
(Personal Injury)

This diary is designed to help us assess your potential loss of income due to the incident. We will need to know about your employment before the incident, at the time of the incident, after the incident, your current employment and your future plans.

- **Please complete the questions in <u>pen</u> (not pencil).**
- **Please make sure you sign and date this diary below.**
- IF AT THE TIME OF THE INCIDENT (OR SINCE) YOU WERE SELF-EMPLOYED, PLEASE ATTACH A DESCRIPTION OF YOUR BUSINESS, SUMMARY OF PLANS (WITH AND WITHOUT YOUR INCIDENT), FINANCIAL STATEMENTS, OR STATEMENT OF BUSINESS ACTIVITIES AND CONTACT DETAILS FOR YOUR ACCOUNTANT (IF APPLICABLE).
- IF YOU HAVE A RESUME PLEASE ATTACH TO THIS DIARY. IF FOR ANY OF YOUR PREVIOUS JOBS YOU HAVE A RECORD OF EMPLOYMENT (ROE) OR T4 STATEMENT PLEASE ATTACH COPIES.
- **Please PRINT all your answers.**

Questionnaire Completed by:	
Relation to Plaintiff:	
Date Completed:	

Phone Number:	
Email:	

If you have any questions while completing this form, please contact:
Brown Economic Consulting at our help line:
1-888-BEC-ASST
(232-2778)

EMPLOYMENT/EDUCATION DIARY (*Personal Injury*)

EDUCATION

SECONDARY EDUCATION

Name of High School:

Highest grade completed:

Date completed:

POST-SECONDAY EDUCATION

Name of Institution	Program of study	Dates of attendance	Degree/Diploma/ Certificate received	Date achieved

Current Education Plans: (please specify approximate dates if known)

Future Education Plans: (please specify approximate dates if known)

EMPLOYMENT/EDUCATION DIARY (*Personal Injury*)

PRE-INCIDENT EMPLOYMENT (BEFORE the date of incident)						
Previous Jobs prior to incident* (Also indicate any periods in which you were not working and why)	*Time Period: Start Date and End Date (month/year)*	*Job title & duties*	*Name of Employer (indicate if self-employed)*	*Earnings (hourly rate and/or monthly salary)*	*Hours worked per week and Weeks worked per year*	*Reason for leaving*
					Hours perweek: _____ Weeks per year: _____	
					Hours perweek: _____ Weeks per year: _____	
					Hours perweek: _____ Weeks per year: _____	
					Hours perweek: _____ Weeks per year: _____	
					Hours perweek: _____ Weeks per year: _____	
					Hours perweek: _____ Weeks per year: _____	

* It is important for us to know your work history to determine your career path in the absence of the incident. If however, you have been with the same company for many years, then it is not crucial that you list all your previous jobs.

EMPLOYMENT/EDUCATION DIARY (*Personal Injury*)

EMPLOYMENT AT THE TIME OF THE INCIDENT				
Time Period *(month/year)* Start Date: _____ End Date: _____	**_Job title & duties_**	**_Name of Employer_** *(indicate if self-employed)*	**_Reason for leaving_**	**_Contact person_** Name: _____ Phone: _____
Earnings **_(hourly rate and/or monthly salary)_**	**_Hours worked per week and_** **_Weeks worked per year_** Hours per week: _____ Weeks per year: _____	**_Group Insurance Benefits_** **_(e.g. health plan, dental plan)_** **_If yes, indicate employer contribution (if known)_** Yes / No (please circle one) Employer's contribution: _____	**_Pension Plan Benefits_** **_(e.g. RRSP, private pension plan)_** **_If yes, indicate employer contribution (if known)_** Yes / No (please circle one) Employer's contribution: _____	**_Were you a member of a union or covered by a Collective Agreement?_** **_(please attach if possible)_** Yes / No (please circle one) Name of Union: _____
Would you have remained in this position in the absence of the incident?	**YES / NO** (circle one)	**If No, what were your plans?**		
Do you think there were further prospects for advancement in this position?	**YES / NO** (circle one)	**Specify:**		
OTHER COMMENTS (if you feel there is more we should know about your employment at the time of the incident which would help in our analysis of your potential earning capacity please indicate it here):				

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POST-INCIDENT EMPLOYMENT (AFTER THE DATE OF THE INCIDENT)
Also indicate any periods you were not working and why

JOB #1

Time Period	*Job title & duties*	*Name of Employer* (indicate if self-employed)	*Reason for leaving*	*Contact person*
Start Date: _____ End Date: _____				Name: _____ Phone: _____

Earnings (hourly rate and/or monthly salary)	*Hours worked per week and Weeks worked per year*	*Group Insurance Benefits (e.g. health, dental plan) If yes, indicate employer contribution (if known)*	*Pension Plan Benefits (e.g. RRSP, private pension plan) If yes, indicate employer contribution (if known)*	*Were you a member of a union or covered by a Collective Agreement? (please attach if possible)*
	Hours per week: _____ Weeks per year: _____	Yes / No (please circle one) Employer's contribution: _____	Yes / No (please circle one) Employer's contribution: _____	Yes / No (please circle one) Name of Union: _____

JOB #2

Time Period	*Job title & duties*	*Name of Employer* (indicate if self-employed)	*Reason for leaving*	*Contact person*
Start Date: _____ End Date: _____				Name: _____ Phone: _____

Earnings (hourly rate and/or monthly salary)	*Hours worked per week and Weeks worked per year*	*Group Insurance Benefits (e.g. health, dental plan) If yes, indicate employer contribution (if known)*	*Pension Plan Benefits (e.g. RRSP, private pension plan) If yes, indicate employer contribution (if known)*	*Were you a member of a union or covered by a Collective Agreement? (please attach if possible)*
	Hours per week: _____ Weeks per year: _____	Yes / No (please circle one) Employer's contribution: _____	Yes / No (please circle one) Employer's contribution: _____	Yes / No (please circle one) Name of Union: _____

toll free 1-888-232-2778
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fax 403.571.0932
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POST-INCIDENT **(Current Employment)** complete this page if different from page 4				
Time Period *(month/year)* Start Date: _____ End Date: _____	Job title & duties	***Name of Employer*** *(indicate if self-employed)*	***Reason for leaving***	***Contact person*** Name: _____ Phone: _____
Earnings ***(hourly rate and/or*** ***monthly salary)***	***Hours worked per week*** ***and*** ***Weeks worked per year*** Hours per week: _____ Weeks per year: _____	***Group Insurance Benefits*** ***(e.g. health plan, dental*** ***plan)*** ***If yes, indicate employer*** ***contribution (if known)*** Yes / No (please circle one) Employer's contribution: _____	***Pension Plan Benefits*** ***(e.g. RRSP, private pension*** ***plan)*** ***If yes, indicate employer*** ***contribution (if known)*** Yes / No (please circle one) Employer's contribution: _____	***Were you a member of*** ***a union or covered by a*** ***Collective Agreement?*** ***(please attach if*** ***possible)*** Yes / No (please circle one) Name of Union: _____
OTHER COMMENTS (if you feel there is more we should know about your employment at the time of the incident which would help in our analysis of your potential earning capacity please indicate it here):				