

You must use this form if you wish to be considered as a person in full-time studies under the Québec Perspective Scholarship Program. **Complete only the part(s) that apply to your situation.**

This part must be completed by the person who was **at least 20 weeks pregnant** during their study term.

Section 1 – Student Information

Last name Permanent code assigned by the Ministère

First name Date of birth

Y M D

Study term covered by the application Fall 2024 Winter 2025 Summer 2025

Section 2 – Attestation of Pregnancy

Have the following fields completed by the person who is monitoring your pregnancy (physician, specialized nurse practitioner or member of the Ordre des sages-femmes du Québec).

Physician
 Specialized nurse practitioner
 Member of the Ordre des sages-femmes du Québec

Last name : _____ First name : _____

Telephone number

Permit number : _____

Office address : _____

Date of 20th week of pregnancy : _____ Expected delivery date : _____

Y M D Y M D

This declaration cannot be signed before the date of the 20th week of pregnancy.

Signature of the physician, specialized nurse practitioner or member of the Ordre des sages-femmes du Québec

X _____ Date _____

Y M D

Signature of the student

X _____ Date _____

Y M D

Section 3 – Protection of personal information

By completing this form, you consent to Aide financière aux études collecting your personal information to process your application. Without this information, your application cannot be analyzed and you will not be able to obtain the financial assistance to which you are entitled. You can change your personal information directly in your file or by contacting us.

This part must be completed **by the person who lived with at least one child (theirs or their spouse's)**, during their study term. Please also provide a copy of the birth certificate of the child or children.

Section 1 – Student Information

Last name Permanent code assigned by the Ministère

First name Date of birth

Y M D

Study term covered by the application Fall 2024 Winter 2025 Summer 2025

Section 2 – Family Situation

Were you living with a spouse? Yes No

Information on the dependent child or children

1. Last and first names of the child : _____

Date of birth

Y M D

Please state the number of days per month when you have custody.

September 2024 October 2024 November 2024 December 2024 January 2025 February 2025 March 2025 April 2025 May 2025 June 2025 July 2025 August 2025

Does the child have a major functional disability or mental health disorder?
(If you answered YES, please provide a Family Allowance statement attesting that you are receiving a supplement for a handicapped child or complete part 3 of this form.)

Yes No

Last and first name of the biological or adoptive parent

_____ Signature X _____

Last and first name of the other biological or adoptive parent

_____ Signature X _____

2. Last and first names of the child : _____

Date of birth

Y M D

Please state the number of days per month when you have custody.

September 2024 October 2024 November 2024 December 2024 January 2025 February 2025 March 2025 April 2025 May 2025 June 2025 July 2025 August 2025

Does the child have a major functional disability or mental health disorder?
(If you answered YES, please provide a Family Allowance statement attesting that you are receiving a supplement for a handicapped child or complete part 3 of this form.)

Yes No

Last and first name of the biological or adoptive parent

_____ Signature X _____

Last and first name of the other biological or adoptive parent

_____ Signature X _____

Section 2 – Family Situation (cont.)

Information on the dependent child or children (cont.)

3. Last and first names of the child : Date of birth
Y M D

Please state the number of days per month when you have custody.

September 2024 October 2024 November 2024 December 2024 January 2025 February 2025 March 2025 April 2025 May 2025 June 2025 July 2025 August 2025

Does the child have a major functional disability or mental health disorder?
(If you answered YES, please provide a Family Allowance statement attesting that you are receiving a supplement for a handicapped child or complete part 3 of this form.) Yes No

Last and first name of the biological or adoptive parent
 Signature X

Last and first name of the other biological or adoptive parent
 Signature X

If needed, use a separate information sheet for a 4th child.

Student's Declaration and Signatures

Signature X Date
Y M D

Signature of the student

Place

Last and first names of the Commissioner for Oaths (Please print)

Signature X Date
Y M D

Signature of the Commissioner for Oaths

Place Number

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**Attestation of Situation of the Person Deemed to be in Full-Time Studies
 – Québec Perspective Scholarship Program
 Part 3 – Dependent Child who has a Major Functional Disability
 or Mental Health Disorder**

This part must be completed by **the person who lived**, during their study term, **with at least one child (theirs or their spouse's) who has a major functional disability or mental health disorder that is described in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V-TR)*.**

Please also provide a copy of the birth certificate of the child who has a major functional disability or mental health disorder and, if the child is your spouse's child, complete part 2 of this form or provide a proof of custody.

Section 1 – Student Information

Last name Permanent code assigned by the Ministère

First name Date of birth

Y M D

Study term covered by the application Fall 2024 Winter 2025 Summer 2025

Section 2 – Identification of Student's Dependent Child

Last name Permanent code assigned by the Ministère

First name Date of birth

Y M D

Section 3 – Dependent Child who has a Major Functional Disability or Mental Health Disorder

Have the following fields completed by a physician.

The disability or mental disorder is : Temporary Permanent

Can you confirm that the child's disability or mental disorder results in significant and persistent limitations in accomplishing daily activities? Yes No

State the date on which these significant and persistent strictures began : _____

Y M D

What is the diagnosis? _____

Date of the diagnosis : _____

Y M D

If the child has a major functional disability, check the box corresponding to the type of disability :

Severe visual impairment Yes No

Visual acuity in each eye, after correction by means of appropriate ophthalmic lenses, excluding special optical systems and additions greater than 4.00 dioptres, is not more than 6/21, or the field of vision in each eye is less than 60 degrees in the 180-degree and 90-degree meridians and, in either case, the person is unable to read, write or move about in an unfamiliar environment.

Severe hearing impairment Yes No

The ear having the greater hearing capability is affected by a hearing deficiency evaluated, according to 1992 Standard S3.21 of the American National Standard Institute, to be an average of at least 70 decibels, in aerial conduction, on any of the 500, 1 000 or 2 000 Hertzian frequencies. In that case, you must include an audiogram with this form.

Motor impairment Yes No

Loss, malformation or abnormality in the systems responsible for body motion.

Organic impairment Yes No

Disorder or abnormality in the internal organs forming part of the cardiorespiratory, gastrointestinal or endocrine systems.

Section 3 – Dependent Child who has a Major Functional Disability or Mental Health Disorder (cont.)

Identification and signature of the physician

Last name : First name :

Medical licence number : Telephone number

Profession :

Office address :

Signature of the physician

X Date Y M D

Signature of the student

X Date Y M D

Section 4 – Protection of personal information

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This part must be completed by **the person who, during their study term, suffered from a serious episodic disorder**, whether a serious mental or physical health problem which occurs irregularly.

Section 1 – Student Information

Last name Permanent code assigned by the Ministère

First name Date of birth

Study term covered by the application Fall 2024 Winter 2025 Summer 2025

Section 2 – Serious Episodic Disorder

Have the following fields completed by a physician.

- Does the person have a major and permanent mental or physical health problem? If yes, please specify :
 - Mental health problem : Yes No
 - Physical health problem : Yes No
- Was this person affected by a serious episodic disorder during the study term indicated above? Yes No
 - If you answered YES, did this disorder make it impossible for the person to pursue full-time studies for more than a month? Yes No
- If you answered YES to questions 2 and 2.1, are you able to prove that the disorder is the result of the person's mental or physical health problem? Yes No

Complete your answers by stating which of the medical analysis factors led to the diagnosis :

Identification and signature of the physician

Last name : _____ First name : _____

Medical licence number : _____ Telephone number : _____

Profession : _____

Office address : _____

Signature of the physician

X _____

Date
Y M D

Student's signature

X _____

Date
Y M D

Section 3 – Protection of personal information

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**Attestation of Situation of the Person Deemed to be in Full-Time Studies
 – Québec Perspective Scholarship Program
 Part 5 – Participation in a Social Assistance and Support Program**

This part must be completed by the person who participated in the Social Assistance and Support Program or benefited from the Basic Income Program during their study term.

Section 1 – Student Information

Last name Permanent code assigned by the Ministère

First name Date of birth

_____ Y M D

Study term covered by the application Fall 2024 Winter 2025 Summer 2025

Section 2 – Participation in a Social Assistance and Support Program

Have the following fields completed by an employment assistance officer from Services Québec.

I certify that the person participated, during the study term indicated above, in a social assistance and support measure or program offered under the *Individual and Family Assistance Act*. Yes No

Signature of the employment assistance officer Date

X _____ _____ Y M D

Student's signature Date

X _____ _____ Y M D

Section 3 – Protection of personal information

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**Attestation of Situation of the Person Deemed to be in Full-Time Studies
 – Québec Perspective Scholarship Program
 Part 6 – Attestation of academic accommodations related to attendance**

This part must be completed by the person who was in part-time studies, who had a disability and who benefited from academic accommodations related to attendance during their study term.

Section 1 – Student Information

Last name Permanent code assigned by the Ministère

First name Date of birth

Study term covered by the application Fall 2024 Winter 2025 Summer 2025

Section 2 – Attestation of academic accommodations related to attendance

Have the following fields completed by a person in charge of integrating students with disabilities at your educational institution.

I certify that the person benefited from academic accommodations related to attendance due to a disability during the study term indicated above Yes No

Signature of an authorized person at the educational institution Date

X _____ _____

Student's signature Date

X _____ _____

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