

Client ID no.	Family name (Surname)	Given name(s)
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PREVIOUS CLAIM(S) FOR REFUGEE PROTECTION

25 Have you or your accompanying dependants made previous claims for refugee protection:

	YES	NO
A. In Canada or at a Canadian visa office abroad? ▶	<input type="checkbox"/>	<input type="checkbox"/>
B. In any other country or countries? ▶	<input type="checkbox"/>	<input type="checkbox"/>
C. With the United Nations High Commissioner for Refugees (UNHCR)? ▶	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the above, complete the following:

Date	Who claimed refugee status? (if accompanying dependant, state name)		Refugee claim made in which country	Did you or your accompanying dependant obtain refugee status?	
	YOU	ACCOMPANYING DEPENDANT NAME		YES	NO
Day Month Year _ _ / _ _ / _ _	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
_ _ / _ _ / _ _	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
_ _ / _ _ / _ _	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

BASIC INFORMATION

26 How much money do you have in your possession? ▶ \$ _____

	YES	NO
27 Are you or your accompanying dependants able to pay for health care expenses in Canada? ▶	<input type="checkbox"/>	<input type="checkbox"/>
28 Do you or your accompanying dependants have any health problems (physical or mental)? ▶	<input type="checkbox"/>	<input type="checkbox"/>
29 Have you or your accompanying dependants ever applied for a permanent resident (immigrant) visa or a temporary resident (visitor) visa for Canada or another country before? ▶	<input type="checkbox"/>	<input type="checkbox"/>
30 Have you or your accompanying dependants ever been refused a permanent resident (immigrant) visa or a temporary resident (visitor) visa for Canada or another country? ▶	<input type="checkbox"/>	<input type="checkbox"/>
31 Have you or your accompanying dependants ever been refused admission to Canada or another country, or ever been ordered to leave Canada or another country? ▶	<input type="checkbox"/>	<input type="checkbox"/>
32 Have you or your accompanying dependants ever committed or been party to, charged with or convicted of a crime or an offence in Canada or another country? ▶	<input type="checkbox"/>	<input type="checkbox"/>
33 Have you or your accompanying dependants ever been sought, arrested or detained by the police, the army or any other authority? ▶	<input type="checkbox"/>	<input type="checkbox"/>
34 Have you or your accompanying dependants ever been involved in criminal activities that involve crossing at least one national border (migrant smuggling, human trafficking, drug trafficking, etc.)? ▶	<input type="checkbox"/>	<input type="checkbox"/>
35 Have you or your accompanying dependants ever been involved in:		
A. An act of genocide (acts committed with the intention of destroying a group)? ▶	<input type="checkbox"/>	<input type="checkbox"/>
B. A war crime (ill treatment of civilians in occupied territories, torture, execution of prisoners of war, etc.)? ▶	<input type="checkbox"/>	<input type="checkbox"/>
C. A crime against humanity (murder, extermination, slavery, deportation, imprisonment, torture, sexual violence, persecution or other inhumane act committed against a civilian population)? ▶	<input type="checkbox"/>	<input type="checkbox"/>
36 Have you or your accompanying dependants ever used, planned or advocated the use of armed struggle or violence (attacks, hostage taking, etc.) to reach political, religious or ideological objectives? ▶	<input type="checkbox"/>	<input type="checkbox"/>

IMPORTANT: For any question to which you answered "yes", please provide explanations and to whom it applies (if accompanying dependant, state name).

Question no.	YOU	ACCOMPANYING DEPENDANT	Who? NAME	Explanations
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

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DETAILS REGARDING DEPENDANTS

37 List the following members of your family

- A. Current spouse, including common-law spouse or same-sex partner.
- B. Children, including children born outside of marriage and adopted children.

	SPOUSE	CHILD	CHILD
Family name	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
Given name(s)	<input style="width:95%;" type="text"/> <input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/> <input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/> <input style="width:95%;" type="text"/>
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital status <small>(use one of the categories from question 13)</small>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
Date of birth	<input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Day"/> <input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Month"/> <input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Year"/>	<input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Day"/> <input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Month"/> <input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Year"/>	<input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Day"/> <input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Month"/> <input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Year"/>
City or town of birth	<input style="width:95%;" type="text"/> <input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/> <input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/> <input style="width:95%;" type="text"/>
Country of birth	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
Applying for refugee status in Canada	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Country of citizenship	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
Last country of permanent residence	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
Already lives in Canada?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, status in Canada <small>(permanent, temporary, refugee claimant, etc.)</small>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
Accompanying you in Canada	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Deceased	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
For office use only Client ID number	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>

	CHILD	CHILD	CHILD
Family name	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
Given name(s)	<input style="width:95%;" type="text"/> <input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/> <input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/> <input style="width:95%;" type="text"/>
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital status <small>(use one of the categories from question 13)</small>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
Date of birth	<input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Day"/> <input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Month"/> <input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Year"/>	<input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Day"/> <input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Month"/> <input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Year"/>	<input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Day"/> <input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Month"/> <input style="width:30%; border-bottom: 1px solid black; border-right: 1px solid black; border-left: 1px solid black; border-top: 1px solid black;" type="text" value="Year"/>
City or town of birth	<input style="width:95%;" type="text"/> <input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/> <input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/> <input style="width:95%;" type="text"/>
Country of birth	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
Applying for refugee status in Canada	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Country of citizenship	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
Last country of permanent residence	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
Already lives in Canada?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, status in Canada <small>(permanent, temporary, refugee claimant, etc.)</small>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
Accompanying you in Canada	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Deceased	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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YOUR PARENTS

38 A. Provide the following details about each of your parents

	FATHER	MOTHER												
Family name	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>												
Given name(s)	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>												
Date of birth	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; text-align: center;">Day</td> <td style="width:33%; text-align: center;">Month</td> <td style="width:33%; text-align: center;">Year</td> </tr> <tr> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> </tr> </table>	Day	Month	Year				<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; text-align: center;">Day</td> <td style="width:33%; text-align: center;">Month</td> <td style="width:33%; text-align: center;">Year</td> </tr> <tr> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> </tr> </table>	Day	Month	Year			
Day	Month	Year												
Day	Month	Year												
City or town of birth	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>												
Country of birth	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>												
Date of death (if deceased)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; text-align: center;">Day</td> <td style="width:33%; text-align: center;">Month</td> <td style="width:33%; text-align: center;">Year</td> </tr> <tr> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> </tr> </table>	Day	Month	Year				<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; text-align: center;">Day</td> <td style="width:33%; text-align: center;">Month</td> <td style="width:33%; text-align: center;">Year</td> </tr> <tr> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> </tr> </table>	Day	Month	Year			
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Address	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">No. and street</td></tr> <tr><td style="padding: 2px;">City/Village</td></tr> <tr><td style="padding: 2px;">Province/State/District</td></tr> <tr><td style="padding: 2px;">Country</td></tr> </table>	No. and street	City/Village	Province/State/District	Country	<p style="margin-left: 20px;">If different of your father</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">No. and street</td></tr> <tr><td style="padding: 2px;">City/Village</td></tr> <tr><td style="padding: 2px;">Province/State/District</td></tr> <tr><td style="padding: 2px;">Country</td></tr> </table>	No. and street	City/Village	Province/State/District	Country				
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Country														
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B. SIBLINGS: For unaccompanied minor ONLY

	SIBLING	SIBLING												
Family name	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>												
Given name(s)	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>												
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EDUCATION

39 How many years of education have you successfully completed? ▶ _____ year(s)

40 List all courses and training you have taken since secondary school, beginning with the most recent.

Dates		Name of institution	City, country	Field of study	Certificate or diploma obtained		
FROM	TO				YES	NO	
Month	Year	Month	Year			<input type="checkbox"/>	<input type="checkbox"/>
_	_	_	_			<input type="checkbox"/>	<input type="checkbox"/>
_	_	_	_			<input type="checkbox"/>	<input type="checkbox"/>
_	_	_	_			<input type="checkbox"/>	<input type="checkbox"/>
_	_	_	_			<input type="checkbox"/>	<input type="checkbox"/>
_	_	_	_			<input type="checkbox"/>	<input type="checkbox"/>
_	_	_	_			<input type="checkbox"/>	<input type="checkbox"/>
_	_	_	_			<input type="checkbox"/>	<input type="checkbox"/>

OCCUPATIONS

41 List all the jobs you have held in the last 10 years, beginning with the most recent one.

- Include full-time, part-time and temporary jobs, and self-employment.
- Include any other use of your time, for example: unemployment; study; travel for any reason; stays in hospitals or prisons; and periods spent at home, as a homemaker.
- **Do not exclude any period of time during the last 10 years.**

Dates		Name of employer	City, country	Occupation
FROM	TO			
Month	Year	Month	Year	
_	_	_	_	
_	_	_	_	
_	_	_	_	
_	_	_	_	
_	_	_	_	
_	_	_	_	
_	_	_	_	

GOVERNMENT POSITIONS HELD

42 List any government positions you have held (such as civil servant, judge, police officer)

Dates		Level of jurisdiction (national, regional, municipal, etc.)	Department/Branch (do not use abbreviations)	Activities or positions held
FROM	TO			
Month	Year	Month	Year	
_	_	_	_	
_	_	_	_	
_	_	_	_	
_	_	_	_	
_	_	_	_	
_	_	_	_	

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MILITARY SERVICE

43 Have you done any military or paramilitary service or training? Yes No ▶ If you answered **yes**, answer question **44**.
If you answered **no**, go to question **45**.

44 Was your military or paramilitary service or training mandatory? Yes No ▶

Dates		Rank(s)	Dates and places of any active combat	Unit numbers and names of your commanding officers
FROM	TO			
Month	Year	Month	Year	

ADDRESSES

45 List all addresses where you have lived in the past 10 years, beginning with your current address in Canada.

- Do not forget the street, village or city, province or region and country. If you do not know the number, clearly indicate the location of the lodgings, home or building.
- **Do not exclude any period of time in the past 10 years.**

Dates		No. and street	City/Village (or nearest municipality)	Province/State/District	Country
FROM	TO				
Month	Year	Month	Year		

ORGANIZATIONS

46 Have you ever been member of an organization? Yes No ▶

If yes, list any organizations in which you have been a member or with which you have been associated or have supported, including political, social, youth, student or vocational organizations such as trade unions and professional associations.

Dates		Name of the organization (do not use acronyms)	Type of organization (do not use abbreviations)	Activities or positions held
FROM	TO			
Month	Year	Month	Year	

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CLAIM FOR REFUGEE PROTECTION

47 In which country(ies) do you fear persecution?

48 Who are you afraid of if you were to return to that (those) country(ies)?

49 Why are you claiming refugee protection in Canada?
Please answer in few words. You will have the opportunity to explain all the facts related to your claim to the Immigration and Refugee Board of Canada.

IMPORTANT
THE FOLLOWING SECTION MUST BE SIGNED IN THE PRESENCE OF A REPRESENTATIVE OF THE CANADIAN GOVERNMENT OR AN OFFICIAL APPOINTED BY THE CANADIAN GOVERNMENT.

APPLICANT DECLARATION	INTERPRETER DECLARATION
<p>I, (print full name clearly) _____, do solemnly declare that the information I have given in the foregoing application is truthful, complete and correct, and I make this solemn declaration conscientiously believing it to be true and knowing that it is of the same force and effects as if made under oath.</p> <p>I understand that any false statements or concealment of a material fact may result in my exclusion from Canada and may be grounds for my prosecution or removal.</p> <p>I understand all the foregoing statements, having asked for and obtained an explanation on every point that was not clear to me.</p> <p>I will immediately inform Citizenship and Immigration Canada and the Canada Border Services Agency if any of the information or the answers provided on this form change.</p> <p style="text-align: center;">_____ Signature of applicant</p>	<p>I, (print full name clearly) _____, do solemnly declare that I have faithfully and accurately interpreted in the _____ language the content of this application and any related forms to the person concerned.</p> <p>I have been informed by the person concerned, and I do verily believe, that he/she completely understands the nature and effect of these forms, and I make this solemn declaration conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath.</p> <p style="text-align: center;">_____ Signature of the interpreter</p>

Declared before me at _____ this _____ day of _____

|_|_|_|_|
Year

Signature of the official of the Government of Canada

The information you provide on this form is collected under the authority of the *Immigration and Refugee Protection Act* and will be used for the purpose of assessing your admissibility to Canada according to the requirements of the Act. This information will be retained in the Personal Information Bank CIC PPU 009 entitled Refugee Claim in Canada Case File. This information may be shared with other organizations such as the Canadian Security Intelligence Service (CSIS), Royal Canadian Mounted Police (RCMP), the Immigration and Refugee Board (IRB) and Canadian Border Services Agency (CBSA) in accordance with the consistent use of information under the *Privacy Act* for the purpose of assessing your admissibility to Canada. Under the provisions of the *Privacy Act* and the *Access to Information Act*, individuals have the right to protection and access to their personal information. Instructions for obtaining information are provided in **InfoSource**, a copy of which is located in all Citizenship and Immigration Canada offices.