labour

Department:
Labour
REPUBLIC OF SOUTH AFRICA

Claim Number: .....

FIRST MEDICAL REPORT IN RESPECT OF AN ACCIDENT

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (Act No. 130 OF 1993)

[Section 6A(b) – Commissioner's rules, forms and particulars – Annexure 15]

Names and Surname of employee .....

Identity Number ..... Address: .....

..... Postal Code .....

Name of employer .....

Address .....

..... Postal Code .....

Date of accident .....

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1. Date of your first consultation .....
2. How did the alleged accident happen? .....

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3. Full clinical description of injury (ies) **(not symptoms, signs or syndromes)** .....

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4. Describe briefly any *pre-existing* defect disease .....

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5. X-rays Date ..... By whom .....
(Attach report if available)
6. Surgical Procedures: Date ..... By whom .....
   Brief description .....

.....

7. Anaesthetics: General / Local ..... Duration .....

6. (a) Consultation Yes / No ..... With whom ..... Date .....
   (b) Was the employee referred for physiotherapy? Yes / No ..... Physiotherapist .....

6. (a) Is the employee unfit for work? Yes / No .....
   (b) Possible date fit for: Light duty ..... Normal duty .....

I certify that I have by examination, satisfied myself that the injury(ies) of the employee is the result of the accident as described above.

Signature of Medical Practitioner/Chiropractor .....

Name (Printed) ..... Date (important) .....

Address .....

..... Postal Code ..... Practice number .....

N.B.: This report must be handed to the injured employee or sent to the employer within 14 days from the date of first consultation.

Call Centre No.: 086 010 5350 - Fax No.: (012) 323-8627 or (012) 323-6986
E-mail: cf-info@labour.gov.za - Website: www.labour.gov.za