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 .....

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

.....

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

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

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.

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