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AIDS HELPLINE: 0800-0123-22 Prevention is the cure

GOVERNMENT NOTICE

DEPARTMENT OF LABOUR

No. 1098 **7 August 2003**

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

Under section 6A of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993, as amended), I, Sibongile Winifred Magojo, Compensation Commissioner, hereby prescribe the following forms to be used in the reporting of claims for accidents:

W.Cl. 303 First Medical Report in respect of Post Traumatic Stress Disorder

W.Cl. 304 Progress / Final Medical Report in respect of Post Traumatic Stress Disorder, and for occupational diseases:

W.Cl. 110 Employee Exposure History

W.Cl. 305 Employee Affidavit for an Occupational Disease: When the Employer does not timeously submit Employer's Report of an Occupational Disease (W.Cl. 1)

SW MAGOJO

COMPENSATION COMMISSIONER

15 Jul 2003

Claim Number:.....

FIRST MEDICAL REPORT IN RESPECT OF POST TRAUMATIC STRESS DISORDER

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

(Act No. 130 of 1993)

[Section 6A(b) – Commissioner's Rules, Forms and Particulars – Annexure 21]

Names and Surname of Employee			
Identity Number		Address	
		Postal Code	
Name of Employer			
Address		Postal Code	

1. Date of accident _____ 2. Date of your first consultation _____

3. How did the alleged accident happen? _____

4. Full Psychiatric Diagnosis (Five Axis)

Axis 1 _____

Axis 2 _____

Axis 3 _____

Axis 4 _____

Axis 5 _____

5. Describe briefly any ***pre-existing*** defect or disease _____

6. Special investigations: Date _____ By whom _____

Brief Description

(Attach report if available)

7. Treatment up to present: Date _____ By whom _____

Brief description _____

9. (a) Consultation Yes / No _____ With whom _____ Date _____

10. (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 condition of the employee is the result of the accident as described above.

Signature of General Medical Practitioner / Psychiatrist / Psychologist _____

Name (Printed) _____ Date (important) _____

Address _____

_____ Postal Code _____ Practice number _____

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

W. Cl. 303

Claim Number:.....

*FINAL / PROGRESS MEDICAL REPORT IN RESPECT OF POST TRAUMATIC STRESS DISORDER

(*Delete which is not applicable)

*The Final Medical Report should be accompanied by a full clinical report from the Psychiatrist treating the employee.

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

[Section 6A(b) – Commissioner's Rules, Forms and Particulars – Annexure 22]

Names and Surname of Employee			
Identity Number		Address	
		Postal Code	
Name of Employer			
Address		Postal Code	
Date of Accident			

1. Describe any treatment / test(s) carried out and date(s): .....

.....

.....

2. Prognosis and further treatment? .....

.....

.....

3. (a) From what date has the employee been fit for his/her normal work? .....

(b) On what date is he/she likely to be fit for his/her normal work? .....

4. Has the employee's condition become stabilised? .....

If so, Final 5 Axis Diagnosis:

Axis 1 .....

Axis 2 .....

Axis 3 .....

Axis 4 .....

Axis 5 .....

Describe in detail any present permanent impairment of function as a result of the condition: (Please indicate GAF / SOFAS / SASOP Scale) .....

.....

.....

I certify that I have by examination, satisfied myself that the condition of the employee is the result of the accident.

Signature of Psychiatrist / General Medical Practitioner / Psychologist / Other .....

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

Address .....

..... Practice number .....

NB Progress reports must be submitted on a monthly basis to the employer until the employee's condition has become stabilised when a final medical report should be submitted.

W. Cl. 304

EMPLOYEE AFFIDAVIT FOR AN OCCUPATIONAL DISEASE: WHEN THE EMPLOYER DOES NOT TIMEOUSLY SUBMIT EMPLOYER'S REPORT OF AN OCCUPATIONAL DISEASE (W.CL.1).

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

[Section 6A(b) – Commissioner's Rules, Forms and Particulars – Annexure 24]

This form must be completed by or on behalf of the employee suffering from an occupational disease and sent to the Compensation Commissioner, P O Box 955, Pretoria, 0001

(BLOCK LETTERS)

1. EMPLOYEE:

Surname:.....First name(s):..... Identity No.: .....
Residential Address:.....
.....Postal Code:.....

2. EMPLOYER:

Name of the employer where the occupational disease was contracted:.....
Nature of business:.....
Physical Address:.....
Does the employer still exist?.....
Name of the present employer:.....
Name of the last employer:.....

3. NATURE OF DUTIES PERFORMED RELATED TO THE ALLEGED OCCUPATIONAL DISEASE:

Type of work... ... ... Occupation:.....
Agent/s exposed to:.....
Years of exposure:.....
Describe the manner in which the employee allegedly contracted the disease:
.....
.....
.....

4. Occupational Disease:..... Date of diagnosis: .....
Date of first consultation with a doctor:.....
Name and address of doctor:.....

5. **Attach any of the following supporting documents, *if available*:**

- The salary slip and /or UIF card where exposure occurred
- A sworn statement by a witness familiar with conditions of the workplace
- Any other relevant document

6. DECLARATION

I swear that the information in this form is to the best of my knowledge correct:

.....
SIGNATURE OR LEFT/ RIGHT THUMB OF THE DEPONENT

I certify that before administering the oath /affirmation, I asked the deponent the following questions and wrote down his//her answers in his / her presence:

1) Do you know and understand the contents of the declaration? YES/ NO .....
2) Do you have any objection to taking the prescribed oath? YES / NO .....
3) Do you consider the prescribed oath to be binding on your conscience? YES / NO .....

I certify that the deponent has acknowledged that he/she knows and understands the contents of this declaration which was sworn to/ affirmed before me and the deponent's signature/ thumb print mark was placed thereon in my presence.

.....
COMMISSIONER OF OATHS

Full name .....

Designation (Rank) : .....Ex Officio Republic of South Africa

Date: ..... Place: .....

W.CL. 305

Claim Number: .....

EXPOSURE HISTORY

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

Section 6A(b) – Commissioner's Rules, Forms and Particulars – Annexure 23]

Additional information required in all cases of occupational diseases, where applicable.

NAME OF EMPLOYEE.....

IDENTITY NUMBER.....

1. PLEASE STATE THE PERIOD (S) THE EMPLOYEE WORKED **IN ENVIRONMENTS WITH EXPOSURES RELATED** TO HIS/HER DISEASE. (*Start with the most recent employer*)

EMPLOYER	PERIOD		OCCUPATION	EXPOSURE
	From:	To:		

2. DESCRIPTION OF EXPOSURE EMANATING FROM THE WORKPLACE CONCERNED

2.1 Describe the types of occupations, the work methods used and the materials to which the employee may have been exposed

Examples of occupations: - Mason in a blast furnace; grinding of sandstone; stone mason; monumental mason; welding; boiler making; metals casting; boiler or pipe insulation; quarry work; use of abrasive powders; tunnelling; mine working (surface or underground)

.....

.....

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.....

2.2 Year of first exposure

2.3 The duration / years of exposure (which may not be the same as years in an occupation)

.....

2.4 The frequency of exposure (once per week for an hour or 8 hours every day)

.....

.....

.....

2.5 Provide any objective measurements of exposure where applicable (supply details if possible eg material safety data sheets, risk assessments or results of environmental hygiene assessments)

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3. SMOKING HISTORY

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4. NON OCCUPATIONAL ENVIRONMENTAL OR LEISURE TIME EXPOSURES

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5. ANY RELEVANT ADDITIONAL INFORMATION

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.....

.....

REPORTING OFFICER .....

DATE.....

ADDRESS.....

.....

.....

.....

Telephone number/s.....

.....

W.Cl. 110

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