
GENERAL NOTICE

NOTICE 636 OF 2009

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASED ACT, 1993 (ACT NO. 130 OF 1993)

1. I, Membathisi Mphumzi Shepherd Mdladlana, Minister of Labour, hereby give notice that, after consultation with the Compensation Board and acting under the powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993), I prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rules applicable thereto, appearing in the Schedule to this notice, with effect from **1 April 2009**.
2. The fees appearing in the Schedule are applicable in respect of services rendered on or after **1 April 2009** and **Exclude VAT**.



M M S MDLADLANA
MINISTER OF LABOUR

DATE: 20/03/2009

GENERAL INFORMATION / ALGEMENE INLIGTING

THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

The employee is permitted to freely choose his own service provider e.g. doctor, pharmacy, physiotherapist, hospital, etc. and no interference with this privilege is permitted, as long as it is exercised reasonably and without prejudice to the employee or to the Compensation Fund. The only exception to this rule is in case where an employer, with the approval of the Compensation Fund, provides comprehensive medical aid facilities to his employees, i.e. including hospital, nursing and other services — section 78 of the Compensation for Occupational Injuries and Diseases Act refers.

In terms of section 42 of the Compensation for Occupational Injuries and Diseases Act the Compensation Fund may refer an injured employee to a specialist medical practitioner of his choice for a medical examination and report. Special fees are payable when this service is requested.

In the event of a change of medical practitioner attending to a case, the first doctor in attendance will, except where the case is transferred to a specialist, be regarded as the principal. **To avoid disputes regarding the payment for services rendered, medical practitioners should refrain from treating an employee already under treatment by another doctor without consulting / informing the first doctor.** As a general rule, changes of doctor are not favoured by the Compensation Fund, unless sufficient reasons exist.

According to the National Health Act no 61 of 2003, Section 5, a health care provider may not refuse a person emergency medical treatment. Such a medical service provider should not request the Compensation Fund to authorise such treatment before the claim has been submitted to and accepted by the Compensation Fund. **Pre-authorisation of treatment is not possible and no medical expense will be approved if liability for the claim has not been accepted by the Compensation Fund.**

An employee seeks medical advice at his own risk. If an employee represented to a medical service provider that he is entitled to treatment in terms of the Compensation for Occupational Injuries and Diseases Act, and yet failed to inform the Compensation Commissioner or his employer of any possible grounds for a claim, the Compensation Fund cannot accept responsibility for medical expenses incurred. The Compensation Commissioner could also have reasons not to accept a claim lodged against the Compensation Fund. In such circumstances the employee would be in the same position as any other member of the public regarding payment of his medical expenses.

Please note that from 1 January 2004 a certified copy of an employee's identity document will be required in order for a claim to be registered with the Compensation Fund. If a copy of the identity document is not submitted the claim will not be registered but will be returned to the employer for attachment of a certified copy of the employee's identity document. Furthermore, all supporting documentation submitted to the Compensation Fund must reflect the identity number of the employee. If the identity number is not included such documents can not be processed but will be returned to the sender to add the ID number.

The tariff amounts published in the tariff guides to medical services rendered in terms of the Compensation for Occupational Injuries and Diseases Act do not include VAT. All accounts for services rendered will be assessed without VAT. Only if it is indicated that the service provider is registered as a VAT vendor and a VAT registration number is provided, will VAT be calculated and added to the payment, without being rounded off.

The only exception is the “per diem” tariffs for Private Hospitals that already include VAT.

Please note that there are VAT exempted codes in the private ambulance tariff structure.

DIE WERKNEMER EN DIE MEDIESE DIENSVERSKAFFER

Die werknemer het 'n vrye keuse van diensverskaffer bv. dokter, apteek, fisioterapeut, hospitaal ens. en geen inmenging met hierdie voorreg word toegelaat nie, solank dit redelik en sonder benadeling van die werknemer self of die Vergoedingsfonds uitgeoefen word. Die enigste uitsondering op hierdie reël is in geval waar die werkgewer met die goedkeuring van die Vergoedingskommissaris omvattende geneeskundige dienste aan sy werknemers voorsien, d.i. insluitende hospitaal-, verplegings- en ander dienste — artikel 78 van die Wet op Vergoeding vir Beroepsbeserings en Siektes verwys.

Kragtens die bepaling van artikel 42 van die Wet op Vergoeding vir Beroepsbeserings en Siektes mag die Vergoedingskommissaris 'n beseerde werknemer na 'n ander geneesheer deur homself aangewys verwys vir 'n mediese ondersoek en verslag. Spesiale fooie is betaalbaar vir hierdie diens wat feitlik uitsluitlik deur spesialiste gelewer word.

*In die geval van 'n verandering in geneesheer wat 'n werknemer behandel, sal die eerste geneesheer wat behandeling toegedien het, behalwe waar die werknemer na 'n spesialis verwys is, as die lasgewer beskou word. **Ten einde geskille rakende die betaling vir dienste gelewer te voorkom, moet geneesheer hul daarvan weerhou om 'n werknemer wat reeds onder behandeling is te behandel sonder om die eerste geneesheer in te lig.** Oor die algemeen word verandering van geneesheer, tensy voldoende redes daarvoor bestaan, nie aangemoedig nie.*

*Volgens die Nasionale Gesondheidswet no 61 van 2003 Afdeling 5, mag 'n gesondheidswerker of diensverskaffer nie weier om noodbehandeling te verskaf nie. Die Vergoedingskommissaris kan egter nie sulke behandeling goedkeur alvorens aanspreeklikheid vir die eis kragtens die Wet op Vergoeding vir Beroepsbeserings en Siektes aanvaar is nie. **Vooraf goedkeuring vir behandeling is nie moontlik nie en geen mediese onkoste sal betaal word as die eis nie deur die Vergoedingsfonds aanvaar word nie.***

Dit moet in gedagte gehou word dat 'n werknemer geneeskundige behandeling op sy eie risiko aanvra. As 'n werknemer dus aan 'n geneesheer voorgee dat hy geregtig is op behandeling in terme van die Wet op Vergoeding vir Beroepsbeserings en Siektes en tog versuim om die Vergoedingskommissaris of sy werkgewer in te lig oor enige moontlike gronde vir 'n eis, kan die Vergoedingsfonds geen aanspreeklikheid aanvaar vir geneeskundige onkoste wat aangegaan is nie. Die

Vergoedingskommissaris kan ook rede hê om 'n eis teen die Vergoedingsfonds nie te aanvaar nie. Onder sulke omstandighede sou die werknemer in dieselfde posisie verkeer as enige lid van die publiek wat betaling van sy geneeskundige onkoste betref.

*Neem asseblief kennis dat 'n **gesertifiseerde afskrif van die werknemer se identiteitsdokument benodig word vanaf 1 Januarie 2004** om 'n eis by die Vergoedingsfonds aan te meld. Indien 'n afskrif van die identiteitsdokument nie aangeheg is nie, sal die eis nie geregistreer word nie en die dokumente sal teruggestuur word aan die werkgewer vir die aanheg van die ID dokument. Alle ander dokumentasie wat aan die kantoor gestuur word moet ook die identiteitsnommer aandui. Indien nie aangedui nie, sal die dokumentasie nie verwerk word nie, maar teruggestuur word vir die aanbring van die identiteitsnommer.*

Die bedrae gepubliseer in die handleiding tot tariewe vir dienste gelewer in terme van die Wet op Vergoeding vir Beroepsbeserings en Siektes, sluit BTW uit. Die rekenings vir dienste gelewer word aangeslaan en bereken sonder BTW.

Indien BTW van toepassing is en 'n BTW registrasienommer voorsien is, word BTW bereken en by die betalingsbedrag gevoeg sonder om afgerond te word.

Die enigste uitsondering is die "per diem" tarief vir Privaat Hospitale, wat BTW insluit.

Neem asseblief kennis dat daar tariewe in die kodestruktuur vir privaat ambulanse is waarop BTW nie betaalbaar is nie.

**CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS
FOLLOWS •**

EISE TEEN DIE VERGOEDINGSFONDS WORD AS VOLG GEHANTEER

1. New claims are registered by the Compensation Fund and the **employer is notified of the claim number** allocated to the claim. The allocation of a claim number by the Compensation Fund, does not constitute acceptance of liability for a claim, but means that the injury on duty has been reported to and registered by the Compensation Commissioner. Enquiries regarding claim numbers should be directed to the employer and not to the Compensation Fund. The employer will be in the position to provide the claim number for the employee as well as indicate whether the claim has been accepted by the Compensation Fund • *Nuwe eise word geregistreer deur die Vergoedingsfonds en die **werkgewer word in kennis gestel van die eisnommer**. Navrae aangaande eisnommers moet aan die werkgewer gerig word en nie aan die Vergoedingskommissaris nie. Die werkgewer kan die eisnommer verskaf en ook aandui of die Vergoedingsfonds die eis aanvaar het of nie*
2. If a claim is **accepted** as a COIDA claim, **reasonable medical expenses** will be paid by the Compensation Commissioner • *As 'n eis deur die Vergoedingsfonds **aanvaar** is, sal **redelike mediese koste** betaal word deur die Vergoedingsfonds.*
3. If a claim is **rejected (repudiated)**, accounts for services rendered will not be paid by the Compensation Commissioner. The employer and the employee will be informed of this decision and the injured employee will be liable for payment. • *As 'n eis deur die Vergoedingsfonds afgekeur (**gerepudieer**) word, word rekenings vir dienste gelewer nie deur die Vergoedingsfonds betaal nie. Die betrokke partye insluitend die diensverskaffers word in kennis gestel van die besluit. Die beseerde werknemer is dan aanspreeklik vir betaling van die rekenings.*
4. If **no decision** can be made regarding acceptance of a claim due to inadequate information, the outstanding information will be requested and upon receipt, the claim will again be adjudicated on. Depending on the outcome, the accounts from the service provider will be dealt with as set out in 2 and 3. Please note that there are claims on which a decision might never be taken due to lack of forthcoming information • *Indien **geen besluit** oor die aanvaarding van 'n eis weens 'n gebrek aan inligting geneem kan word nie, sal die uitstaande inligting aangevra word. Met ontvangs van sulke inligting sal die eis heroorweeg word. Afhangende van die uitslag, sal die rekening gehanteer word soos uiteengeset in punte 1 en 2. Ongelukkig bestaan daar eise waaroor 'n besluit nooit geneem kan word nie aangesien die uitstaande inligting nooit verskaf word nie.*

BILLING PROCEDURE • EISPROSEDURE

1. The **first account** for services rendered for an injured employee (INCLUDING the First Medical Report) must be submitted to the employer who will collate all the necessary documents and submit them to the Compensation Commissioner • *Die eerste rekening (INSLUITEND die Eerste Mediese Verslag) vir dienste gelewer aan 'n beseerde werknemer moet aan die werkgever gestuur word, wat die nodige dokumentasie sal versamel en dit aan die Vergoedingskommissaris sal voorlê*
2. Subsequent accounts must be submitted or posted to the closest Labour Centre. It is important that all requirements for the submission of accounts, including supporting information, are met • Daaropvolgende rekeninge moet ingedien of gepos word aan die naaste Arbeidsentrum. Dit is belangrik dat al die voorskrifte vir die indien van rekeninge nagekom word, insluitend die voorsiening van stawende dokumentasie
3. If accounts are still outstanding after 60 days following submission, the service provider should complete an enquiry form, W.Cl 20, and submit it ONCE to the Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za • *Indien rekenings nog uitstaande is na 60 dae vanaf indiening en ontvangserkenning deur die Vergoedingskommissaris, moet die diensverskaffer 'n navraag vorm. W.Cl 20 voltooi en EENMALIG indien by die Arbeidsentrum. Alle inligting oor Arbeidsentrums is beskikbaar op die webblad www.labour.gov.za*
4. If an account has been **partially paid** with no reason indicated on the remittance advice, a duplicate account with the unpaid services clearly marked can be submitted to the Labour Centre, accompanied by a WCl 20 form. (*see website for example of the form). • *Indien 'n rekening gedeeltelik betaal is met geen rede voorsien op die betaaladvies nie, kan 'n duplikaatrekening met die wanbetaling duidelik aangedui, vergesel van 'n WCl 20 vorm by die Arbeidsentrum ingedien word (*sien webblad vir 'n voorbeeld van die vorm)*
5. **Information NOT to be reflected** on the account: Details of the employee's medical aid and the practice number of the referring practitioner • *Inligting wat NIE aangedui moet word op die rekening nie: Besonderhede van die werknemer se mediese fonds en die verwysende geneesheer se praktyknommer*
6. Service providers **should not generate** • *Diensverskaffers moenie die volgende lewer nie:*
 - a. **Multiple accounts** for services rendered on the **same date** i.e. one account for medication and a second account for other services • *Meer as een rekening vir dienste gelewer op dieselfde datum, bv. medikasie op een rekening en ander dienste op 'n tweede rekening*
 - b. **Accumulative accounts** - submit a separate account for every month • *Aaneenlopende rekeninge –lewer 'n aparte rekening vir elke maand*
 - c. **Accounts on the old documents** (W.Cl 4 / W.Cl 5/ W.Cl 5F) New *First Medical Report (W.Cl 4) and Progress / Final Medical Report (W.Cl 5 / W.Cl 5F) forms

are available. The use of the old reporting forms combined with an account (W.CL11) has been discontinued. **Accounts on the old medical reports will not be processed** • *Rekeninge op die ou voorgeskrewe dokumente van die Vergoedingskommissaris. Nuwe *Eerste Mediese Verslag (W.Cl 4) en Vorderings / Finale Mediese Verslag (W.Cl 5) vorms is beskikbaar. Die vorige verslagvorms gekombineer met die rekening (W.CL11) is vervang. Rekeninge op die ou vorms word nie verwerk nie.*

* Examples of the new forms (W.Cl 4 / W.Cl 5 / W.Cl 5F) are available on the website www.labour.gov.za •

* Voorbeelde van die nuwe vorms (W.Cl 4 / W.Cl 5 / W.Cl 5F) is beskikbaar op die webblad www.labour.gov.za

MINIMUM REQUIREMENTS FOR ACCOUNTS RENDERED •
MINIMUM VEREISTES VIR REKENINGE GELEWER

Minimum information to be indicated on accounts submitted to the Compensation Fund • *Minimum besonderhede wat aangedui moet word op rekeninge gelewer aan die Vergoedingsfonds*

- Name of employee and ID number • *Naam van werknemer en ID nommer*
- Name of employer and registration number if available • *Naam van werkgever en registrasienommer indien beskikbaar*
- Compensation Fund claim number • *Vergoedingsfonds eisnommer*
- DATE OF ACCIDENT (not only the service date) • *DATUM VAN BESERING (nie slegs die diensdatum nie)*
- Service provider's reference or account number • *Diensverskaffer se verwysing of rekening nommer*
- The practice number (changes of address should be reported to BHF) • *Die praktyknommer (adresveranderings moet by BHF aangemeld word)*
- VAT registration number (VAT will not be paid if a VAT registration number is not supplied on the account) • *BTW registrasienommer (BTW sal nie betaal word as die BTW registrasienommer nie voorsien word nie)*
- Date of service (the actual service date must be indicated: the invoice date is not acceptable) • *Diensdatum (die werklike diensdatum moet aangedui word: die datum van lewering van die rekening is nie aanvaarbaar nie)*
- Item codes according to the officially published tariff guides • *Item kodes soos aangedui in die amptelik gepubliseerde handleidings tot tariewe*
- Amount claimed per item code and total of account • *Bedrag geëis per itemkode en totaal van rekening.*
- It is important that all requirements for the submission of accounts are met, including supporting information, e.g. • *Dit is belangrik dat alle voorskrifte vir die indien van rekeninge insluitend dokumentasie nagekom word bv.*
 - All pharmacy or medication accounts must be accompanied by the original scripts • *Alle apteekrekenings vir medikasie moet vergesel word van die oorspronklike voorskrifte*
 - The referral notes from the treating practitioner must accompany all other medical service providers' accounts. • *Die verwysingsbriewe van die behandelende geneesheer moet rekeninge van ander mediese diensverskaffers vergesel*

TARIFF OF FEES IN RESPECT OF PHYSIOTHERAPY SERVICES
FROM 1 APRIL 2009

001. Unless timely steps are taken to cancel an appointment, the relevant fee may be charged to the employee. Each case shall be considered on merit and if the circumstances warrant, no fee shall be charged.
002. In exceptional cases where the tariff fee is disproportionately low in relation to the actual services rendered by a physiotherapist, a higher fee may be negotiated. Conversely, if the fee is disproportionately high in relation to the actual services rendered, a lower fee than that in the tariff should be charged.
003. If there is no active physiotherapy treatment for a period of 3 calendar months, treatment will be deemed to have been terminated. Subsequent physiotherapy treatment will require a new referral letter and a new treatment plan. For treatment beyond 20 treatment sessions, a rehabilitation progress report (attached to this guide to tariffs and fees) must be submitted to the Compensation Fund.
004. Prolonged and costly treatment should only be embarked upon after negotiation with the treating medical practitioner and approval from the Compensation Fund.
005. After a series of 20 treatment sessions for the same condition, the physiotherapist must refer the employee back to the medical practitioner with a rehabilitation progress report on the progress made. If further physiotherapy treatment is required the medical practitioner must submit a progress report and the rehabilitation progress report to the Compensation Commissioner indicating the necessity for further treatment and the number of further sessions required. The rehabilitation progress report (attached to this guide to tariffs and fees) must be submitted to the Compensation Fund

at the start of treatment and again after every 20 sessions of treatment. Without such a report payment for sessions in excess of 20 shall not be considered.

006. "After hour treatment" shall mean all physiotherapy performed where emergency treatment is required after working hours, before 07:00 and after 17:00 on weekdays, and any treatment over a weekend. In cases where the physiotherapist's scheduled working hours extend after 17:00 and before 07:00 during the week or weekend, the above rule shall not apply and the treatment fee shall be that of the normal listed tariff. The fee for all treatment under this rule shall be the total fee for the treatment plus 50 per cent. Modifier 006 must then be quoted after the appropriate tariff code to indicate that this rule is applicable.

For the purpose of this rule:

Emergency treatment means *a justifiable emergency physiotherapy procedure, where failure to provide the procedure immediately would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the patient's life in serious jeopardy.* **Routine physiotherapy does not qualify as emergency treatment.**

007. The physiotherapist shall submit his / her account for treatment to the employer of the employee concerned.
008. When an employee is referred for physiotherapy treatment after a surgical procedure, a new set of 20 sessions will commence.
009. AM and PM treatment sessions should be specified and medically motivated for on the progress rehabilitation report.
011. Cost of material does not include consumables (e.g. ultrasound gel, massage oil, gloves, alcohol swabs, facial tissues, paper towels and etc.)

012. An account for services rendered will be assessed and added without VAT. VAT is then calculated and added to the final payment amount.
013. Where a physiotherapist is called out from residence or rooms to an employee's home or hospital, travelling fees can be charged for travelling more than 16km in total. If more than one employee is attended to during the course of a trip, the full travelling expenses must be divided pro rata between the relevant employees. A physiotherapist is not entitled to charge any travelling expenses or travelling time to his / her rooms.
014. Physiotherapy services rendered in a hospital or nursing facility.
015. The services of a physiotherapist shall be available only on referral from the treating medical practitioner. Where a physiotherapist's letterhead is used as a referral letter, it must bear the medical practitioner's signature, date and stamp. The referral letter for any physiotherapy treatment provided should be submitted to the Compensation Commissioner with the account for such services.

MODIFIERS GOVERNING THE TARIFF

- 0001 To be quoted after appropriate treatment codes when rule 001 is applicable.
- 0006 Add 50% of the total fee for the treatment.
- 0013 R5.00 per km for each kilometre in excess of 16 kilometres travelled in total in own car e.g. 19 km total = 3 x R5.00 = R15.00 (No travelling time allowed)
0014. Treatment in a nursing facility.

PHYSIOTHERAPY TARIFF OF FEES 2009

Please note that no other treatment techniques may be charged in conjunction with the codes below except for evaluation, visiting, extra treatment time and cost of material codes. A simple evaluation code cannot be charged simultaneously with a complex evaluation / reassessment code.

Code	Service type	Service description	Tariff
72701	Evaluation level 1 (to be fully documented)	Applies to simple evaluation once at first visit only. It should not be used for each condition. A treatment plan / rehabilitation progress report must be submitted at the initiation of treatment.	R 137.40
72702	Complex evaluation (to be fully documented)	Complex evaluation / counselling once at first visit only. Applies to multiple complex injuries only. It should not be used for each condition. A treatment plan / rehabilitation progress report must be submitted at the initiation of treatment.	R 206.00
72703	Re-assessment	Complete re-assessment or counselling, during the course of treatment. This code also to be used for one physical performance test that must be fully documented and a report provided to the CF.	R 68.50
72901	Treatment at nursing home	Relevant fee plus (to be charged only once per day and not with every hospital visit)	R 50.20
72305	Bed program	Bed exercises / passive movements.	R 50.20
72509	Extra treatment time	Should be medically motivated for e.g. complicated condition. This code can only be claimed once per treatment session.	R 76.30
72903	Domiciliary treatments	Apply only when medically motivated: relevant fee plus.	R 91.40
72925	Level 1 chest pathology	Applies to simple chest conditions / injuries. Multiple treatment techniques to be used.	R 225.00

Code	Service type	Service description	Tariff
72926	Level 2 chest pathology	Applies only to complex chest conditions / injuries that require undivided attention of the physiotherapist. Multiple treatment techniques to be used.	R 371.80
72921	Simple spinal treatment	Applies to simple spinal injuries / conditions. Multiple treatment techniques to be used.	R 330.50
72923	Complex spinal treatment	Applies only to complex conditions / injuries to the vertebral column. Multiple treatment techniques to be used.	R 477.30
72928	Simple soft tissue / peripheral joint injuries or other general treatment	Applies to simple soft tissue / peripheral joint injuries / conditions. Multiple treatment techniques to be used.	R 330.50
72927	Complex soft tissue / peripheral joint injuries or other general treatment	Applies only to multiple severe / complex injuries. Multiple treatment techniques to be used.	R 431.60
72501	Rehabilitation	Rehabilitation first 30 minutes, where the pathology requires the undivided attention of the physiotherapist	R 238.65
72503	Rehabilitation central nervous system	Also includes spinal rehabilitation (cannot be charged for bed exercises / passive movements only)	R 477.30
72939	Cost of material	Single items below R 1572.00 (VAT excl) may be charged for at cost price plus 20% storage and handling fees. The invoice must be attached to the account. Cost of materials does not cover consumables See the attached Annexure A for consumables and Annexure B for equipment and or appliances that are considered reasonable to be used with code 72939	

ANNEXURE A**LIST OF CONSUMABLES****To be used with code 72939****Service providers may add on 20% for storage and handling**

NAME OF PRODUCT	UNIT	APPROX UNIT PRICE (excl VAT)
Tubigrip (A & B white)	1	92.11
Self adhesive disposable electrodes (one set per employee is payable)	1	36.84
Sports		
<i>Taping / Strapping (type & quantity must be specified)</i>		
Elastoplast 75mm x 4.5	1	78.95
Coverol	1	58.77
Leukotape	1	78.95
Magic Grip Spray	1	57.02
Fixomull	1	65.79
Leukoban 50-75mm x 4.5m	1	30.70
Other		
Incontinence electrodes for pathway EMG	1	175.44
EMG flat electrodes	1	14.91
(should be medically justified)		

ANNEXURE B**List of equipment / appliances to be used with code 72939**

Service providers may add on 20% for storage and handling

Equipment not payable if the same were already supplied by an Orthotist /
Prosthetist to the same employee

NAME OF PRODUCT	UNIT	APPROX UNIT PRICE (excl VAT)
Hot / cold packs	1	35.09
<u>Braces</u>		
Cervical collar	1	35.09
Lumbar brace	1	206.14
Standard heel cups	pair	52.63
Cliniband	1	28.07
Fit band 5.5cm	1	71.05
Fit band 30cm	1	249.12
Peak flow meter	1	164.04
Peak flow meter	2	1.75

Claim Number: -----

REHABILITATION PROGRESS REPORT
COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASE ACT

Names and Surname of Employee _____

Identity Number _____ Address _____

_____ Postal Code _____

Name of Employer _____

Address _____

_____ Postal Code _____

Date of Accident _____

1. Date of first treatment _____ Provider who provided first treatment _____

2. Initial clinical presentation and functional status _____

3. Name of referring medical practitioner _____ Date of referral _____

4. Describe patient's current symptoms and functional status _____

5. Are there any complicating factors that may prolong rehabilitation or delay recovery (specify)? _____

6. Overall goal of treatment: _____

7. Number of sessions already delivered _____ Progress achieved _____

Claim Number: _____

8. Number of sessions required_____ Treatment plan for proposed treatment sessions_____

9. From what date has the employee been fit for his/her normal work?_____

10. Is the employee fully rehabilitated / has the employee obtained the highest level of function?_____

11. If so, describe in detail any present permanent anatomical defect and / or impairment of function as a result of the accident (R.O.M, if any must be indicated in degrees at each specific joint)_____

I certify that I have by examination, satisfied myself that the injury(ies) are as a result of the accident.

Signature of rehabilitation service provider_____

Name(Printed) _____ Date(Important)_____

Address_____

Practice number_____

NB: Rehabilitation progress reports must be submitted on a monthly basis and attached to the submitted accounts.