ANNEXURE A

APPLICATION FORM: TEMPORARY INCAPACITY LEAVE SHORT PERIODS

INSTRUCTIONS ON COMPLETION OF THE APPLICATION FORM

- 1 This application form must be completed in respect of an incapacity leave period of less than 30 working days.
- This form comprises six parts, i.e. Parts A to F and Appendix 1. The employee must complete Parts A and B or C. The Supervisor must complete Part D, the HR Department must complete Part E and the Head of Department or his or her delegate must complete Part F. Appendix 1 must be completed by the Medical Practitioner at the time of consulting and the issuing of the medical certificate.
- 3 Please ensure that this form is duly completed, signed and accompanied by all the required supporting documents, as missing or omitted information will delay finalisation of the application. You are reminded that the submission of a medical certificate with each application is mandatory. Please also refer to the *Determination and Directive on Leave of Absence in the Public Service* for the requirements in respect of medical certificates.
- This application is subject to an investigation in terms of the *Determination and Directive on Leave of Absence in the Public Service*, read together with the *Policy and Procedure on Incapacity Leave and Ill-health Retirement*. In the light hereof, the Employer shall grant temporary incapacity leave **conditionally** for a maximum period of 29 working days with full pay subject to the outcome of the said investigation. Please note that if this application is declined based upon the outcome of the investigation, the period of temporary incapacity leave shall be converted to annual leave or granted as unpaid leave.
- Cognisance must also be taken of the fact that the employee is responsible for proving to the Employer's satisfaction that s/he is too ill/injured to be at work. The employee is, in keeping with the principles contained in item 10 of Schedule 8 of the Labour Relations Act, 1995, therefore afforded the opportunity to submit additional medical evidence related to the medical condition of the employee together with his/her application. This may include but is not limited to medical reports from a specialist, blood test results, x-ray results, scan results, etc. or any additional motivation/evidence which the employee deems relevant and which supports and states his/her case, and which the employer should take into account in contemplating the application for incapacity leave.
- 6 This application form and supporting documentation is classified as 'Confidential' in terms of the Minimum Information Security Standards.
- 7 Checklist on documents required for all applications:
- 7.1 Medical certificate (Compulsory) (Appendix 1 to Annexure A must at all times accompany the medical certificate)
- 7.2 Medical report(s) (Recommended)
- 7.3 Blood tests, x-ray results, scan results, etc. (Recommended)
- 7.4 Additional written motivation (Recommended)
- 7.5 A Shift Roster must be attached to the application if an employee is a shift worker.
- An employee may include the recommended supporting documents in a sealed envelope addressed for the attention of the Health Risk Manager. This sealed envelope must be attached to this application form.
- 9 If an employee is unable to complete the form he/she may seek assistance from his/her supervisor, a colleague, the Human Resources component, a relative or friend to assist him or her.
- 10 It is important to note that failure to grant consent may have a detrimental effect on the outcome of the application because it will be assessed based on the available information at the employer's disposal.

FOR OFFICIAL USE	
Employee Name	
Persal no	
Unique case number	
Incapacity Leave Period	



PART A: DETAILS OF EMPLOYEE (All fields in this part are mandatory and must be completed)

1. PERSONAL	PARTI	CUL	ARS												
Surname				First n	ames	s									
Title							Persal	No							
Date of Birth							ID No								
Gender:		Fem	ale						Ма	ıle					
Nature of appointment:	Permant Full time	_		Perma Part T	manent Time		Tempo Full Ti						Temp Part	oorary Time	
Shift Worker		Yes							No)					
Address during	Absence	9					Email	Addr	ess						
Contact numbers	home)			work	<				mobil	le				
Medical Aid:				Medical Aid Plan/Option:											
Date of first appointment in Public Service				Date of appointment to present post (if different):											
Salary Level				Annual salary/ Packag	TCE	CE		Last day at v		at wo	ork				
Period of Absence	Start date		,		End	date	Number of incapacity leave days applied for								
DETAILS OF YOUR ILLNESS/INJURY 2.1. Describe in your own words the illness/injury (not injury on duty) that has given rise to this application specifically the symptoms/impairments that disable you and prevent you from working.															
2.2. How does your illness, injury (not injury on duty), or condition limit your ability to work/function? (Please elaborate which elements of your job you are prevented from performing)															



2.3. Detail exactly what medication you are takin recently added / given, as well as the dosage		i.e. chronic m	nedication,	new medication			
2.4. Please indicate whether you suffer from any	side effects from the medic	ation and the	nature the	ereof.			
3. DECLARATION*							
I hereby declare and warrant that the information provided is factual, true and correct, and that no material information has been withheld or any relevant circumstances omitted. Any falsification of information in this regard may form grounds for disciplinary action. I understand that the burden of proof of my illness/injury rests with me and that I am afforded the opportunity to submit additional medical evidence and motivation to this effect with this application. I know and understand that if I fail to do so, it would be of my own choice and that the omission of such information may impact upon the decision regarding my application.							
SIGNATURE OF EMPLOYEE:			Date:				
In the event that this application is signed by the following information:	anyone other than the en	nployee , i.e.	a Third Pa	arty, please provide			
Full name and surname of signing third party:							
Telephone no of third party		Cell No of th party	ird				
Reason for signing on employee's behalf							
Relationship of signing third party to Employee (e.g. spouse, colleague, union representative, friend etc.)							
SIGNATURE OF THIRD PARTY if Employee is unable to sign for any reason, e.g. employee is in hospital, unconscious etc.			Date:				



PART B: EMPLOYEE CONSENT FORM

Instructions	DI		
2	Please see paragraph 10 of the i If you choose not to grant conse		part but proceed to part C of this application form.
Authority			
I		, ID No	
PERSAL No	an	employee of	(hereinafter referred to a
may hold any m Risk Manager a illness, injury or of all prescribed	edical records relating to me and /o ppointed by the Employer any and condition including, but not limited to medications and treatments, progr	or any treatment or advice all details and information, o, all clinical records, labora ess reports and summarie	, clinic, health care provider or any other relevant person that provided to furnish and release to the Employer and Health specifically including confidential information, relating to an atory results (including blood and other tests), x-rays, records, correspondence between my medical practitioner and any medical treatment of any nature.
	or the Employer and the Health Ri		to privacy and acknowledge and agree that this is necessar nter alia, the provision of incapacity leave and/or ill healt
			the Employer for the purpose of considering and evaluating no other purpose without my prior written consent.
well as any othe retirement benef	r information that may be in the Emp	oloyer's possession, includ s and specifications and re	Risk Manager any and all information referred to above a ing previous applications for incapacity leave and /or ill healt lated records. I further authorise the Health Risk Manager to to the Employer.
I confirm that a p	photocopy of this authority shall be	as effective and valid as th	e original.
Consent to Und	dergo Medical Examination		
to undergo medi		and other tests including,	or incapacity leave and/or ill health benefits, I may be required but not limited to, blood tests, for the purpose of determining
or other required costs of any suc	d evaluation as they may determine	on reasonable prior notice ity of the Health Risk Mana	te appointments on my behalf to attend any required medicalle to me and that, subject to the provisions set out below, the ger. I understand that if I fail to honour the latter appointment from me.
the Employer or notice to the em	r its representatives and agree that	t in the event that I negled fication, any and all costs of	d all required documentation and information as advised b t or fail to attend any appointment without reasonable pric or charges that may be incurred consequent upon my failur
Indemnity			
of, or arising from	m the furnishing of any information a	as provided for herein unle	m whatsoever, which may be made against them as a resu ss such claim or furnishing of my information provided herei mployees and its Health Risk Manager and its agents.
Signed at	on this the	day of	20 .



SIGNATURE/MARK OF EMPLOY	YEE:				Date:			
	In the event that this Consent Form is signed by anyone other than the employee , i.e. a Third Party, please provide the following information:							
Full Name and Surname of signing third party:								
Telephone no of third party			Cell No of the party	ird				
Reason for signing on employee's								
Relationship of signing third party (e.g. spouse, colleague, Union reprised etc.)								
SIGNATURE OF THIRD PARTY i unable to sign for any reason. (E. in hospital, Unconscious etc.)			Da	te:				
Signature of witness			Date					
Full Name & Surname :								
Tel No. :								
Cell No. :								



PART C: EMPLOYEE REFUSAL OF CONSENT FORM

Instruct		4			
2	Please see paragraph 10 of the instructions on p Do not complete this part if you completed Part				
Authority					
Authority					
		, ID No _			
PERSAL		e of the			(hereinafter
referred to	o as "the Employer") hereby refuse to give consent –				
sp re re	r the release to the Employer and Health Risk Manager pecifically including confidential information, relating to an cords, laboratory results (including blood and other tests), ports and summaries, correspondence between my media nere I have been a patient or from whom I have received an	ny illness, injury x-rays, records cal practitioner a	or condition in of all prescribed and any other p	ncluding, with medication who	ithout limitation, all clinical n and treatments, progress has provided treatment or
b) To	be subjected to any further medical examination that the l	Employer or its !	Health Risk Mar	nager may	require.
consider a		ill health retirem	ent application.		
as a resu	ndemnify the Employer and its Health Risk Manager a It of, or arising from my refusal to give consent. on this theday of				ay be made agamst them
SIGNAT	URE/MARK OF EMPLOYEE::			Date:	
	vent that this Consent Form is signed by anyone but the owing information:	e applicant hin	n or herself, i.e	. a Third P	arty, please provide
Full Nan	ne and Surname of signing third party:				
Telepho	ne no of third party		Cell No of thir	-d	
	for signing on employee's behalf		-	•	
	ship of signing third party to Employee (e.g. spouse, e, Union representative, friend etc.)				
	URE OF THIRD PARTY if Employee / Applicant is unable or any reason. (E.g. Applicant is in hospital, Unconscious			Date:	



Signature of witness					Date				
Full Name & Surname :	;								
Tel No. :									
Cell No. :									
PART D: MOTIVATION	OF SU	PERVISC	PR/MANAGER (A	All fields	in this part are	e mandato	ry and mu	ust be comp	leted)
Describe your obsework. Attach a sep		•	•		s's illness has h	ad on the e	employee a	and his/her a	bility to
2 JOB DETAILS OF	THE E	MPLOYE							
Job Title:					ne employee ha	ve staff	Yes	No	
Prescribed daily hours worker, average daily			ift		_			1	
Does this employee perform night shifts	Yes	No							
3 EMPLOYEE'S CU	RRENT	JOB DE	MANDS						
PLEASE SPECIFY THE (Total percentage to			E (%) TIME SPE	NT ON:					
NATURE OF	PERCE		NATURE OF	P	ERCENTAGE	NATURE	OF	PERCEN	TAGE
TYCK.			TACK.			TVCK.			

(Total percentage t	o equal 10070j				
NATURE OF	PERCENTAGE	NATURE OF	PERCENTAGE	NATURE OF	PERCENTAGE
TVCK.		TVCK.		TVCK.	
Managerial		Administrative		Clerical	
Supervisory		Light Manual		Heavy Manual	
Machine Operator		Travel		Driver	
Other (Specify)					

4 RECOMMENDATION OF SUPERVISOR	OR WANAGER.						
Application supported	Application not supported						
If not supported, please provide reasons for not supporting application							



Full Name & Surname of Supervisor / Manager:	
Designation	
Tel Number:	
Cell Number:	
SIGNATURE OF SUPERVISOR/ MANAGER	
Date:	

PART E: REPORT TO THE HEALTH RISK MANAGER COMPLETED BY THE HUMAN RESOURCES DIVISION

IMPORTANT NOTES						
The following documentation must be attached:						
Medical certificate with Appendix 1 (supplied by emp	loyee)					
Medical reports, (if supplied by employee)						
Blood tests, x-ray results, scan results, etc. (If supplied	ed by employee)					
Additional written motivation (If supplied by employee	e)					
PERSAL printout of all leave records of the previous	& current leave cy	cles (PER	SAL Function #4	4.5.1 Option 5)		
Copies of all sick leave forms and medical certificates	s for the current a	nd previou	s leave cycle			
Sealed envelope marked for the attention of the Heal	Ith Risk Manager	(If supplied	by employee)			
A Shift Roster if an employee is a shift worker						
Contact details of Human Resource Manager or D	Delegate(as per w	ritten dele	egation) :			
Name	Surname					
Designation:						
Department:	Province National					
Department address:						
Contact number:	Work		Cellphone	Fax Number		
Email address:						
Signature:						
Date:						
Contact details of alternative person in Human Ro	esource					
Name and Surname of contact person in department		Designation	on			
Contact number:	Work		Cellphone	Fax Number		
E-mail address						
		·				



DECLARATION						
I hereby declare that the information provided is to the best of my knowledge true and correct and that no material information has either been withheld or omitted.						
Print Name & Surname						
Signature of Head of Department or delegate (as per written delegations)		Date				

PART F: FINAL DECISION BY THE HEAD OF DEPARTMENT (All Fields are mandatory and must be completed)

Temporary incapacity leave requested	Approved	Partially Approved	Not Approved		
COMMENTS/CONDITIONS/INSTRUCTIO			1		
Print Name					
Signature of Head of Department or delegations		D	ate		

FOR OFFICIAL USE

ACTIONS	CAPTURED/EXECUTED	CHECKED & SIGNED OFF
Employee notified of	Name &	Name &
decision	Surname:	Surname:
	Date actioned	Date
		actioned
Decision captured on	Name &	Name &
PERSAL	Surname:	Surname:
	Date actioned	Date
		actioned
Salary overpayment	Name &	Name &
recovered or Leave	Surname:	Surname:
without pay	Date actioned	Date
implemented, (if		actioned
applicable)		
Referred to EHW (if	Name &	Name &
applicable)	Surname:	Surname:
	Date actioned	Date
		actioned
Referred to Labour	Name &	Name &
Relations (if applicable)	Surname:	Surname:
	Date actioned	Date
		actioned



ANNEXURE B

APPLICATION FORM TEMPORARY INCAPACITY LEAVE

LONG PERIOD

INSTRUCTIONS ON COMPLETION OF THE APPLICATION FORM

- 1 This application form must be completed in respect of incapacity leave periods of 30 working days or more.
- 2 This form comprises seven parts, i.e. Parts A to G. The employee must complete Parts A and B or C. The employee's attending Medical Practitioner must complete Part D. (It is the employee's responsibility to have the said part completed by the Medical Practitioner.) The Supervisor must complete Part E, the HR Department must complete Part F and the Head of Department or his or her delegate must complete Part G.
- 3 Please ensure that this form is duly completed, signed and accompanied by all the required supporting documents, because missing or omitted information will delay finalisation of the application. You are reminded that the submission of a medical certificate with each application is mandatory. Please also refer to the Determination and Directive on Leave of Absence in the Public Service for the requirements in respect of medical certificates.
- 4 This application is subject to an investigation in terms of the Determination and Directive on Leave of Absence in the Public Service, read together with the Policy and Procedure on Incapacity Leave and III-health Retirement. In the light hereof, the Employer shall grant temporary incapacity leave conditionally for a maximum period of 30 working days with full pay subject to the outcome of the said investigation. Please note that if this application is declined based upon the outcome of the investigation the period of temporary incapacity leave shall be converted to either annual leave or be unpaid leave.
- Cognisance must also be taken of the fact that the employee is responsible to for proving to the Employer's satisfaction that s/he is too ill/injured to be at work. The employee is, in keeping with the principles contained in item 10 of Schedule 8 of the Labour Relations Act, 1995, therefore afforded the opportunity to submit additional medical evidence related to the medical condition of the employee together with his/her application. This may include but is not limited to medical reports from a specialist, blood test results, x-ray results, scan results, etc. or any additional motivation/evidence which the employee deems relevant and which supports and states his/her case and which the Employer should take into account in contemplating the application for incapacity leave.
- 6 This application form and supporting documentation is classified as 'Confidential' in terms of the Minimum Information Security Standards.
- 7 Checklist on documents required for all applications:
 - 7.1 Medical certificate (Compulsory)
 - 7.2 Medical report(s) (Recommended)
 - 7.3 Blood tests, x-ray results, scan results, etc. (Recommended)
 - 7.4 Additional written motivation (Recommended)
 - 7.5 A Shift Roster must be attached to the application if an employee is a shift worker.
- 8 An employee may include the recommended supporting documents in a sealed envelope addressed for the attention of the Health Risk Manager. This sealed envelope must be attached to this application form.
- 9 If an employee is unable to complete the form he/she may seek assistance from his/her supervisor, a colleague, the Human Resources component, a relative or friend to assist him or her.
- 10 It is important to note that failure to grant consent may have a detrimental effect on the outcome of the application because it will be assessed only based on the available information at the employer's disposal.

FOR OFFICIAL USE

Employee Name	
PERSAL NO	
Unique case number	
Incapacity Leave Period	



First names

PART A: DETAILS OF EMPLOYEE (all fields in this part are mandatory and must be completed)

1. PERSONAL PARTICULARS

Surname

Title												
Date of birth							ID	no				
Persal no							Ge	nder	Female		Male	
Nature of appointment:		Permanent full time		Permanent part time				Temporary: full time		e Temporary part time		
Shift worker		Yes			No					•		
Address during abse	ence											
Contact numbers		home				work	(cell pho	one	
Email address												
Medical aid					Med	ical a	id plar	n/option:				
Date of first appointr Public Service						ate of appointment to resent post (if different):						
Salary level		Annual basic sala package				y/TC	E					
Last day at work												
Period of absence		Start date					End date					
Number of incapacit days applied for	y leave											
2. WORK HISTORY	,											
2.1 Please provide a	history o	of all previous	jobs ir	n or	outside	of the	Publ	ic Ser\	vice in the last	five (5) y	years	
From	То		Emplo	yer		W	ork o	designa	ation			
APPLICATION FORM T	EMPOP 4	ADV INCADACI	TVIE	\\/E	LONG	DEDIOL						,



2.2 Describe the duties and functions of y	our current job:				
2.3 Details of education and training :					
2.4 Please give details of your highest leading to the second of the sec		rell as training (acad		•	
Year qualified	Institution		Qualification		
2.5 Considering your training and exper	ionoo for what alterna	ativo iobe do vou co	neidar vaurea	If qualified or s	skilled within
or outside your current department?		ilive jobs do you co	iisidei youise	ii qualilleu oi s	SKIIIGU WILIIIII
, i					
3. DETAILS OF YOUR ILLNESS/INJUF	RY				
3.1 Describe in your own words the illne	ess/injury (not injury or	n duty) that has give	en rise to this a	application spe	ecifically the
symptoms/impairments that disable					
3.2 In your opinion, will you recover					
from current ill-health to the extent	Yes	No		Uncertain	
of returning to work? If no or uncertain, list and detail the work	dutios vou are unable	to porform			
ii no or uncertain, list and detail the work	dulles you are unable	to periorii.			



3.3	Which o	f the fo	llowing are	you unable to d	lo d	lue to your illness	/inju	ry? K	indly tick	below:				
PHYSIC	CAL				N	MENTAL			ACTIVITIES OF DAILY LIVING					
Lifting			Walking		U	Inderstanding			Eating		Spo	Sport		
Stair climbing	g		Sitting	Sitting		Short term memory		Dressin	g		Use of public transport			
Bending	_		Kneeling			concentration			Bathing		Red	Recreational activities		
Standin	ng		Talking			ollowing estructions			Domest chores,	ic				
Seeing			Hearing		С	alculation			Shoppin	ıg				
Using hands						ong term nemory			Driving					
3.4 I	Please o	ive the	e details of h	ospitalisation ir	n th	e past 5 years.		1		•	•			
Name of		Please give the details of hospitalisation in hospital Reason for admission Date admitted			Date discharged	Relevant Medical Practitioner's name		(Specialisation		Detail of Treatmen	nt /			
				tion you are tak well as the dos		for your conditio e for each.	n. Li	st all,	i.e. chro	nic medic	cation, n	ew medica	ition	
3.6 F	Please i	ndicate	if you suffe	r from any side	eff	fects from the me	dicat	tion a	nd the na	ature ther	eof.			



23.7 Have you consulted any of the following practitioners, including but not limited to: physiotherapist, occupational therapist, psychologist, audiologist, speech therapist, dietician Ves No during the period applied for?									
If yes, kindly provide de						I.	ı	1	
4 DECLARATION	4 DECLARATION								
information has been regard may form grou with me and that I am effect with this applic	warrant that the inforn withheld or any relevands for disciplinary a afforded the opportunation. I know and und information may impa	ant circur ction. I un nity to sur erstand ti	mstances omitte nderstand that ti bmit additional i hat if I fail to do	ed. Any falsifica he burden of pr medical eviden so, it would be	tion of info roof of my ce and mor of my own	ormatic illness/ tivatior	n in i injur i to tl	this y rests nis	
SIGNATURE OF EMPLOYEE: Date:									
In the event that this the following informa	application is signed t tion	y anyone	e other than the	employee , i.e.	a Third Pa	rty, ple	ase p	rovide	;
Full name and surname	e of signing third party:								
Telephone no of third party	home		work		cell phon	е			
Reason for signing on	employee's behalf								
Relationship of signing third party to Employee (e.g. spouse, colleague, union representative, friend etc.)									
SIGNATURE OF THIRD PARTY if Employee is unable to sign for any reason, e.g. employee is in hospital, unconscious etc.									



PART B: EMPLOYEE CONSENT FORM

Instructions 1 Please see paragraph	10 of the instru	rtions on nage 1			
2 If you choose not to			part but procee	ed to part C of this	s application form.
·		•		•	
Authority					
Authority		ID. No			
PERSAL No	an emplo	, ID NO _ vee of			hereinafter referred to as
"the Employer") hereby authorise any that may hold any medical records related Health Risk Manager appointed by the to any illness, injury or condition including records of all prescribed medications and any other person who has provided any nature whatsoever.	medical practition ating to me and /o Employer any and ng, but not limited and treatments, pro	er, hospital, institut r any treatment or all details and infor to, all clinical record gress reports and s	advice provided mation, specifical ls, laboratory res ummaries, corres	care provider or a to furnish and releatly including confidults (including bloos spondence betwee	any other relevant person ease to the Employer and ential information, relating and and other tests), x-rays, en my medical practitioner
I know and understand that by providing and essential for the Employer and the retirement benefits.					
This authority is limited to such informa an application for incapacity leave and/					
I hereby authorise the Employer to disc well as any other information that may health retirement benefits, medical rep Manager to disclose and make available	be in the Employ orts, job description	ver's possession, ir ons and specificati	cluding previous ons and related	applications for in records. I further a	ncapacity leave and /or ill
I confirm that a photocopy of this autho	rity shall be as effe	ective and valid as	he original.		
Consent to Undergo Medical Examin	ation				
I acknowledge that for the Employer t required to undergo medical and/or ps determining the nature, extent and dura	ychological evalua	tion and other tests	s including, but n		
I further acknowledge that the Employe or other required evaluation as they ma costs of any such evaluation shall be the the Employer shall recover the fruitless	y determine on re responsibility of the	asonable prior notic ne Health Risk Mana	ce to me and that ager. I understand	, subject to the pro	visions set out below, the
I undertake to present myself for any a the Employer or its representatives an notice to the employer and without according to attend will be payable in full by me o	d agree that in the eptable justification	e event that I negle n, any and all costs	ct or fail to attend	d any appointmen	t without reasonable prior
Indemnity					
I hereby indemnify the Employer and its of, or arising from the furnishing of any i arose from or is as a result of any wilful	nformation as prov	rided for herein unle	ess such claim or	furnishing of my in	formation provided herein
Signed at	on this the	day of		20	



SIGNATURE/MARK OF EMPLOYEE:				Date:							
In the event that this consent form is signed by any following information:				her thar	the emp	oloye	e , i.e. a Th	ird Par	rty, please	provide the)
Full name and surname of signing third party:											
Telephone no of third party	home			work			cell phone				
Reason for signing on employee's behalf											
Relationship of signing third party to employee (e.g. spouse, colleague, Union representative, friend etc.)											
SIGNATURE OF THIRD PARTY if Employee is unable to sign for any reason. (E.g. Employee is in hospital, Unconscious etc.)								Date	:		
Signature of witness					Date						
Full Name & Surname :											
Tel No. :											
Cell No. :											



PART C: EMPLOYEE REFUSAL OF CONSENT FORM

		aragraph 10 of th lete this part if y							
Authority									
<u> </u>					, [[) No			;
PERSAL No referred to as "the	Employer")	hereby refuse to o	an e	employee :-	of the				(hereinafter
specifically records, la reports an	/ including of boratory res d summaries	confidential informults (including blo	nation, relation od and othe e between m	ng to any r tests), x- ny medica	illness, rays, re Il practit	, injury or o ecords of all tioner and a	condition inc prescribed any other pe	luding, without medication and t rson who has p	ails and information, limitation, all clinical treatments, progress rovided treatment or
b) To be subj	jected to any	further medical e	examination	that the E	mployer	r or its Heal	th Risk Man	ager may require	ə .
consider available Indemnity I hereby indemnit as a result of, or a	fy the Empl arising fron	oyer and its Hea n my refusal to g	ilth Risk Ma ive consent	inager ag t.	ainst a	ny claim w	hatsoever,	·	made against them
SIGNATURE/N	MARK OF E	MPLOYEE::						Date:	
	In the eve	ent that this cor ty, please prov					t the applic		erself, i.e. a
		signing third pa	ırty:			<u> </u>			1
Telephone no o party	of third	home		wo	ork			cell phone	
	signing thin	ployee's behalf rd party to Emplore representative,							
SIGNATURE OF THIRD PARTY if Employee is unable to sign for any reason. (E.g. Employee is in hospital, Unconscious etc.)								Date:	
Signature of w	/itness					Date			
Full Name & S							1		
Tel No. :									
Call No :									



PART D: MEDICAL REPORT (To be completed by the attending Medical Practitioner)

Dear Medical Practitioner,

We would appreciate your co-operation in providing the information requested in this form.

This employee, your patient, has exhausted all of the normal sick leave of 36 working days to which he/she is legally entitled for the entire three-year sick leave cycle, and is now requesting additional fully paid additional sick leave. In the context of this consultation, should you decide to recommend the granting of sick leave he/she will be required to apply for Temporary Incapacity Leave for the period in question.

Importantly, such fully paid Temporary Incapacity leave is not a right in terms of the Basic Conditions of Employment Act, (BCEA) but is essentially an employee privilege granted entirely at the discretion of the Head of Department. Consequently, more detailed objective medical information is required, in addition to the standard Medical Certificate.

Failure to provide detailed and adequate medical data in this Medical Report may result in there being insufficient information on which to make an informed decision and as such the employee may well be granted unpaid leave for the duration of his / her absence.

Thank you sincerely for taking the time to complete this report. Your assistance is greatly appreciated.

1. EMPLOYEE DETAILS	3
Title	
Surname	
First name	
Persal number	
Id number	
Date of birth	
How long have you been the	e patient's treating Medical Practitioner?
On which date did you first of	consult with the patient?
On which date did you last o	consult with the nationt?
On which date did you last t	Software with the patient:



2. EN	MPLOYEE'S MEDICAL DETAILS
2.1. DI	AGNOSIS
	What is the nature of the illness/injury from which the patient is suffering? Please indicate the diagnosis DSM/ICD), if applicable.
2.1.2. V	What were the presenting symptoms and when did they first appear?
2.1.3. F	Please detail any co-morbid conditions that will impact on the employee's recovery and incapacity.
2.2. IM	MPAIRMENT
	Describe fully the nature and extent of the physical impairment which resulted in the patient's inability to perform is/her normal duties
2.2.2. D	Describe fully the nature and extent of the cognitive and /or psychological impairment which resulted in the patient's inability to perform his/her normal duties. (Including MMSE/MoCA if applicable).
	n the case of a psychiatric condition, please indicate the GAF at the beginning of treatment and the GAF at review consultations.



2.3. MEDICAL HISTORY									
2.3.1. Please detail the onset and history of the illness and/ or injury, including the presenting symptoms.									
232 Please r	rovide d	etails of a	ALL consultations	with the	natient o	ver at least the na	ast six (6)	months	in the table
below:	novido d	otalio oi z	ALL CONSCITATIONS	with the	pationt o	voi at lodot the pt	JOE OIX (O)	1110111110	iii tilo tablo
Date of consultation									
2.3.3. Please r	provide d	etails of o	other medical prac	ctitioners	' referrals	or of hospital adr	missions o	ver at le	east the past 3
years.			р			or or moophian and			Just and past o
						Relevant			
Name of hospital	Reason		Date admitted	Date discha	rand	Medical Practitioner's	Speciality		Treatment /
Поѕрітаі	aumss	SIOH		uiscria	igeu	name			surgery
2.4. INVESTIG									
2.4.1. Please d	etail the	objective	findings, such as UDE COPIES OF	blood te	sts, x-ray	reports, ECG, Ec	hocardiog	raphy fi	ndings, histology
resuits, e	ili. PLEF	ASE INCL	ODE COPIES OF	ALL AV	AILADLE	REPURIS.			
			ditions, please indi	icate the	most rec	ent ventricular eje	ction frac	tion and	the grading of
dyspnoe	a accord	ing to the	NYHA.						
2.4.3. In the ca	se of pul	monary d	lisorders, kindly in	clude the	most red	cent lung function	test resul	ts.	
		-	•						



2.4.4. In the case of spinal (neck and back) conditions, kindly include latest radiology report.
2.45 In view animing about the noticest underse firsther investigations? Places comment
2.4.5. In your opinion should the patient undergo further investigations? Please comment.
2.5. TREATMENT
2.5.1. Please provide details of present treatment, i.e. medication (product name, strength, dosage and duration),
rehabilitation, counselling, etc. and how successful they have been.
2.5.2. Please comment on the patient's compliance with and response to all treatment initiated.
2.5.3. Please detail any complications or side effects of treatment experienced by the patient.
2.5.4. In your opinion could further treatment (e.g. pharmacological / surgical and/or rehabilitation) be beneficial to the
patient.



2.6. PROGNOSIS								
2.6.1. What, in your opinion, is the estimated long term prognosis for the patient's condition?								
2.6.2. In your opinion, is the present incapacity temporary or permanent? In the case of temporary incapacity, please indicate an estimated time period and what is the patient's occupational prognosis (if applicable)?								
2.6.3. What is the estimated degree or	f recovery? Kindly tick below	v:						
No recovery	Partial recovery		Full recove	ery				
2.7. WORK ABILITY	1							
2.7.1. Do the patient's work duties and labour related issues affect the ability?		Yes		No				
If yes, please provide details:		l .						
2.7.2. Please comment on the genera	I mobility of the patient and	indicate if assist	tive devices a	re required.				
2.7.3. In your opinion, if the patient is	not able to perform his/her of	duties, what ada	pted or altern	ate duties are	possible?			



2.8. GENERAL			
2.8.1. Please add any general c employee's application.	omments in respect of this	patient's state of health that	will assist in assessing the
3. MEDICAL PRACTITIONER	 X'S DETAILS:		
Surname:	_	Initials:	
Practice No:		HPCSA Registration No:	
Email Address:		Fax No:	
Address:			
Telephone Number:		Cell phone numbe	r:
4. DECLARATION			
I hereby declare and warrant the information has been withheld	nat the information given nor any relevant circums	above is factual, true and ostances omitted.	correct and that no material
Signed at	on this	Day of	20
SIGNATURE OF MEDICAL PRAC	CTITIONER		



PART E: MOTIVATION OF SUPERVISOR/MANAGER (All fields in this part are mandatory and must be completed)

 Describe your observations and the impact the employee's illness had on the employee and his/her ability to work. Attach a separate page as an annexure if necessary 													
2. JOB DETAILS	OF THE	EMPLOYE	Ε										
Job Title:					Does the reporting		•	e staff	Yes	;		No	
Prescribed daily ho work/Average daily work										•	,		
Nature of Appointment	Full-	time		Fulltim work	e: Shift		Part-tir		Contrac				
Does this employed perform night shifts	1 1 11 11 11 11 11 11 11		•				No						
If the employee per requested to under section 17 (3) (b) or has been issued ar please attach a cop	go a medi f the BCE nd health r	cal examin A, 1997 as elated issu	ation in amenders	terms of ed? (If a been ide	report	Yes			N	No			
3. EMPLOYEES	CURREN	IT JOB DE	MANDS	6									
PLEASE SPECIFY (Total percentage			E (%) TI	ME SPE	NT IN:								
TASK	PERCE	NTAGE:	TASK		PER	CENT	AGE:	TASK			PER	CENTA	AGE:
Managerial			Admin	istrative				Clerical					
Supervisory			Light N	Manual				Heavy M	lanua	I			
Machine Operator			Travel					Driver					
Other (Specify)					•								



4. RECOMMENDATION OF	SUPERVISOR OR MA	NAGER:					
Application Supported		Application	Not suppor	ted			
If not supported please provide	e reasons for not suppor	ting application	ı				
Full Name & Surname of Supe	ervisor / Manager:						
Designation							
Tel Number:		Cell phone	Number:				
Date:							
SIGNATURE OF SUPERVISO	OR/ MANAGER						
IMPORTANT NOTES 1. The following documentation 2. Medical certificate (SUPPLIE 3. Medical reports (If supplied k 4. Blood tests, x-ray results, sc 5. Additional written motivation 6. PERSAL printout of all leave 7. Copies of all sick leave forms 8. Sealed envelope marked for 1 9. A Shift Roster if an employee 10.Medical report issued in term 1. CONTACT DETAILS OF I	n must be attached: D BY EMPLOYEE) by employee) an results, etc. (If supplied by employee) records of the previous as and medical certificates the attention of the Healt e is a shift worker	ed by employee e) & current leave s for the current h Risk Manager the BCEA, 1997) cycles (PER and previo (If supplied as amended	RSAL Fun us leave o I by emplo d (if applie	ction #4.5 cycle oyee) cable)		
Name		Surname					
Designation:							
Department:			Province		N	lational	
Department address:							
Contact number (Code & no):	Work Cell phone				ernative x no		
Email address:		1		I		1	
Signature:			Date:				



2. CONTACT DETAILS OF ALTERN	ATIVE PERS	N IN HR			
Name and Surname of contact person in department			Designation		
Contact number (Code & no):	Work		Alternative	Fax no	
E-mail address					
3. DECLARATION					
I hereby declare that the information properties information has either been withheld		the best of my kno	wledge true and	correct and that	no material
Print Name & Surname					
Signature of Head of Department or delewritten delegations)	egate (as per			Date	

PART G: FINAL DECISION BY THE HEAD OF DEPARTMENT (All Fields are mandatory and must be completed)

Temporary incapacity leave requested	Approved	Partially Approved	Not Approved		
COMMENTS/CONDITIONS/INSTRUC	CTIONS:				
Print Name					
Signature of Head of Department or delegate as per written delegations	·		Date		

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ACTIONS	CAPTURED/EXECUTED	CHECKED & SIGNED OFF
Employee notified of decision	Name & Surname:	Name & Surname:
	Date actioned	Date actioned
Decision captured on PERSAL	Name & Surname:	Name & Surname:
	Date actioned	Date actioned
Salary overpayment recovered or Leave	Name & Surname:	Name & Surname:
without pay implemented, (if applicable)	Date actioned	Date actioned
Referred to EHW (if applicable)	Name & Surname:	Name & Surname:
	Date actioned	Date actioned
Referred to Labour Relations (if applicable)	Name & Surname:	Name & Surname:
	Date actioned	Date actioned

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ANNEXURE E APPLICATION/REPORT FORM: ILL-HEALTH RETIREMENT

INSTRUCTIONS ON COMPLETION OF THE APPLICATION/REPORT FORM

- This form comprises seven parts, i.e. Parts A to G. The employee must complete Parts A and B or C. The employee's attending medical practitioner must complete Part D. (It is the employee's responsibility to have the said part completed by the medical practitioner.) The Supervisor must complete Part E, The HR Department must complete Part F and the Head of Department or his or her delegate must complete Part G.
- Please ensure that this form is duly completed, signed and accompanied by all the required supporting documents. Missing or omitted information may either delay or have a detrimental impact on the finalisation/consideration of the application.
- The medical practitioner(s), preferably a medical specialist treating the employee on whom the application is based, must complete Part D of the form. If a general practitioner completes part D of the form, an additional report from a medical specialist specialist specialising in the medical field related to the employee's condition, must be obtained and also submitted. If more than one medical practitioner is involved in the treatment of the employee, each of the medical practitioners must complete a part D of the form.
- This application is subject to an investigation in terms of the *Policy and Procedure on Incapacity Leave and Ill-health Retirement (PILIR)* read together with *item 10 of Schedule 8 of the Labour Relations Act, 1995, as amended.*
- Cognisance must be taken of the fact that it is the responsibility of the employee to prove that s/he is too ill to continue working. The employee is, in keeping with the principles contained in item 10 of Schedule 8 of the Labour Relations Act, 1995, afforded the opportunity to submit additional medical evidence related to the medical condition of the employee together with his/her application, including but not limited to, medical reports from a specialist, blood test results, x-ray results, scan results, etc. or any additional motivation/evidence which the employee deems relevant and which supports and motivates his/her case and which the employer should take into account in contemplating the application for incapacity leave.
- This application form and supporting documentation is classified as 'Confidential' in terms of the Minimum Information Security Standards.
- 7 Checklist on documents required for all applications:
 - 7.1 A certified copy of employee's Identity Document (compulsory)
 - 7.2 Medical report(s) (compulsory)
 - 7.3 Blood tests, x-ray results, scan results, etc. (compulsory)
 - 7.4 Additional written motivation (recommended)
- An employee may include the recommended supporting documents in a sealed envelope addressed for the attention of the Health Risk Manager. This sealed envelope must be attached to this application form.
- If an employee is unable to complete the form he/she may seek assistance from his/her supervisor, a colleague, the Human Resources component, a relative or friend to assist him or her.
- 10 It is important to note that failure to grant consent may have a detrimental effect on the outcome of the application because the application will be assessed based on the available information at the employer's disposal.

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Employee Name	
PERSAL NO	
Unique case number	



PART A: DETAILS OF EMPLOYEE (all fields in this part are mandatory and must be completed)

1. PERSONAL PA	RTICUL	ARS											
Surname						First	names						
Title													
Date of birth							ID no						
Persal no							Gender		Female		M	ale	
Nature of appointme	nt:	Permanent full time			Perma part ti				mporary time			porary time	
Shift worker		Yes			No								
Address during abse	ence												
Contact numbers		home				work				cell ph	one		
Email address			•					•					
Medical aid		Medical aid plan/option:					otion:						
Date of first appoint Public Service	ment in	Date of appointment to present post (if different):											
Salary level					nual ba ckage	sic sala	ary/TCE						
Last day at work							1						
Period of absence		Start date						Er	ıd date				
Number of incapacit days applied for	ty leave												
2. WORK HISTORY	1												
2.1. Please provide a	history o	of all previous	jobs ir	or	outside	of the I	Public Se	rvice	in the last	five (5) y	ears		
From	То		Emplo	yer		W	ork desig	natio	n				



2.2. Describe the duti	ies and functions of yo	ur current job:		
2.3. Details of educa	ation and training :			
2.4. Please give det	ails of your highest lev	el of education as well	as training (acade	emic, technical, in service).
Year qualified	I	nstitution		Qualification
2.5. Considering you outside your cu	ur training and experie rrent department?	nce, for what alternativ	e jobs do you cons	sider yourself qualified or skilled within or



3.	3. DETAILS OF YOUR ILLNESS/INJURY						
3.1.	Describe in your own words the illr symptoms/impairments that disable				en rise to this	application sp	ecifically the
		Γ					
3.2.	In your opinion, will you recover from current ill-health to the extent of returning to work?	Yes		No		Uncertain	
If no	or uncertain, list and detail the work	duties you are	e unable to pe	rform.			



3.3. Which of the following are you unable to do due to your illness/injury? Kindly tick below:											
PHYSICAL				MENTAL			ACTIVIT	ACTIVITIES OF DAILY LIVING			
Lifting		Walking			Understanding		Eating		Sport	Sport	
Stair climbing		Sitting			Short term memory		Dressin g		Use of public transport		
Bending		Kneeling			Concentration		Bathing		Recreational activities		
Standing				Following instructions		Domest ic chores,					
Seeing		Hearing	ring		Calculation		Shoppi ng				
Using hands					Long term memory		Driving				
3.4. Please giv	e the de	tails of hos	pitalis	sation in the	e past 5 years.			Γ		1	
Name of hospital	Reason admiss		Date	admitted	Date discharge		Relevant medical practitioner's name				ent /
			_								
	3.5. Detail exactly what medication you are taking for your condition. List all, i.e. chronic medication, new medication recently added / given, as well as the dosage for each.										



3.6. Please indicate if you suffer from any side effects from the medication and the nature thereof.									
3.7. Have you consulted any of the following practitioners, including but not limited to: physiotherapist, occupational therapist, psychologist, audiologist, speech therapist, dietician during the period applied for?									
If yes, kindly provide de	tails.								
4. DECLARATION*									
I hereby declare and									
information has been may form grounds for	r disciplinary ac	tion. I unders	tand that the burd	den of proof of l	my illnes	s/injury	rests wi	th me	
and that I am afforded application. I know an	d understand th	at if I fail to do	so, it would be o						
information may impa	ct upon the dec	ision regardin	g my application.						
SIGNATURE OF EMPL	OYEE:		Date:				:		
In the event that this apprinted information	plication is signed	d by anyone oth	ner than the employ	ree , i.e. a Third P	arty, plea	ise provi	de the foll	owing	
Full name and surname	of signing third p	party:							
Telephone no of third party	home		work		Cell pho	one			
Reason for signing on e	employee's behal	f							
Relationship of signing third party to Employee (e.g. spouse, colleague, union representative, friend etc.)									
SIGNATURE OF THIRI unable to sign for any re in hospital, unconscious	eason, e.g. empl	•			Date:				



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PART B: EMPLOYEE CONSENT FORM

Instructions

- 1 Please see paragraph 10 of the instructions on page 1.
- 2 If you choose not to grant consent do not complete this part but proceed to part C of this application form.

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_	u	u	Ш	v	ı	Ц	. y	1

I	, ID No	
PERSAL No	an employee of	(hereinafter referred to as
"the Employer") hereb	by authorise any medical practitioner, hospital, institution, clinic, h	ealth care provider or any other relevant person that
may hold any medical	records relating to me and /or any treatment or advice provided t	to furnish and release to the Employer and Health
Risk Manager appointe	ed by the Employer any and all details and information, specifical	lly including confidential information, relating to any
illness, injury or condit	tion including, but not limited to, all clinical records, laboratory res	sults (including blood and other tests), x-rays,
records of all prescribe	ed medications and treatments, progress reports and summaries,	, correspondence between my medical practitioner
and any other person v	who has provided treatment or where I have been a patient or fro	om whom I have received any medical treatment of
any nature whatsoever	r.	

I know and understand that by providing this authority I am curtailing my right to privacy and acknowledge and agree that this is necessary and essential for the Employer and the Health Risk Manager to consider, inter alia, the provision of incapacity leave and/or ill health retirement benefits.

This authority is limited to such information as may reasonably be required by the Employer for the purpose of considering and evaluating an application for incapacity leave and/or ill health retirement benefits and for no other purpose without my prior written consent.

I hereby authorise the Employer to disclose and make available to the Health Risk Manager any and all information referred to above as well as any other information that may be in the Employer's possession, including previous applications for incapacity leave and /or ill health retirement benefits, medical reports, job descriptions and specifications and related records. I further authorise the Health Risk Manager to disclose and make available any of the aforegoing information in its possession to the Employer.

I confirm that a photocopy of this authority shall be as effective and valid as the original.

Consent to Undergo Medical Examination

I acknowledge that for the Employer to consider and evaluate any application for incapacity leave and/or ill health benefits, I may be required to undergo medical and/or psychological evaluation and other tests including, but not limited to, blood tests, for the purpose of determining the nature, extent and duration of any incapacity or illness suffered by me.

I further acknowledge that the Employer, or its Health Risk Manager, may make appointments on my behalf to attend any required medical or other required evaluation as they may determine on reasonable prior notice to me and that, subject to the provisions set out below, the costs of any such evaluation shall be the responsibility of the Health Risk Manager. I understand that if I fail to honour the latter appointment, the Employer shall recover the fruitless expenditure for the missed appointment from me.

I undertake to present myself for any appointment timeously and with any and all required documentation and information as advised by the Employer or its representatives and agree that in the event that I neglect or fail to attend any appointment without reasonable prior notice to the employer and without acceptable justification, any and all costs or charges that may be incurred consequent upon my failure to attend will be payable in full by me on demand by the Employer.

Indemnity

I hereby indemnify the Employer and its Health Risk Manager against any claim whatsoever, which may be made against them as a result of, or arising from the furnishing of any information as provided for herein unless such claim or furnishing of my information provided herein arose from or is as a result of any wilful or negligent act of the Employer, its employees and its Health Risk Manager and its agents.

Signed at	on this the	day of	20	
APPLICATION FORM ILL	-HEALTH RETIREMENT			



SIGNATURE/MARK OF EMPLOYEE:								ı	Date:	
In the event that this consent form is signed by anyon following information:			ne oth	er than	the emplo	oye	e , i.e. a Third	d Party,	, please pr	ovide the
Full name and surname of signing third party:										
Telephone no of third party	home	ome		work				cell phone		
Reason for signing on employee's behalf										
Relationship of signing third party to employee (e.g. spouse, colleague, Union representative, friend etc.)										
SIGNATURE OF THIRD PARTY if Employee is unable to sign for any reason. (E.g. Employee is in hospital, Unconscious etc.)								Date:		
Signature of witness				Date				I		
Full Name & Surname :										
Tel No. :										
Cell No. :										



PART C: EMPLOYEE REFUSAL OF CONSENT FORM

Instructions	.							
	ase see paragraph 1	10 of the in	structions on pag	e 1.				
	not complete this p		. •					
	· ·	•	•					
Authority					ID Na			
PERSAL No								
	to give consent-		an employe	e or the			(nereinaiter rei	erred to as the Employer)
a)	a) for the release to the Employer and Health Risk Manager appointed by the Employer of any and all details and information, specifically including confidential information, relating to any illness, injury or condition including, without limitation, all clinical records, laboratory results (including blood and other tests), x-rays, records of all prescribed medication and treatments, progress reports and summaries, correspondence between my medical practitioner and any other person who has provided treatment or where I have been a patient or from whom I have received any medical treatment of any nature whatsoever.							
b)	To be subjected to	o any furthe	er medical examina	tion that the	e employe	r or its Health Risk Mar	ager may require).
	derstand that by not passess my incapacity					Employer and the Hea	alth Risk Manager	will only consider available
Indemnity								
I hereby indemnify the Employer and its Health Risk Manager against any claim whatsoever, which may be made against them as a result of, or arising from my refusal to give consent. Signed at on this theday of 20								
SIGNATU	RE/MARK OF EI	MPLOYE	E::				Date:	
	nt that this conse	nt form is	signed by anyo	ne but th	e applic	ant him or herself,	i.e. a Third Pa	rty, please provide
Full name	and surname of	signing th	ird party:					
Telephone	e no of third	home		work			cell phone	
Reason fo	or signing on emp	loyee's be	ehalf					
	nip of signing third Union represent			spouse,				
	RE OF THIRD PA ny reason. (E.g. e			ble to			Date:	
Signature	of witness					Date		
Full Name	e & Surname :					, 1		
Tel No. :								
Cell No. :								

PART D: MEDICAL REPORT (To be completed by the attending medical practitioner)

Dear Medical Practitioner,

We would appreciate your co-operation in providing the information requested in this form.

This employee, your patient, is consulting you as he/she is not well. Importantly, this ill-health retirement application is subject to an assessment and is granted entirely at the discretion of the Head of Department. Consequently, far more detailed objective medical information is required.

Failure to provide detailed and adequate medical data in this Medical Report will result in there being insufficient information on which to make an informed decision and as such the employee may not be granted ill-health retirement.

Thank you sincerely for taking the time to complete this report. Your assistance is greatly appreciated.

1. EMPLOYEE DETAILS	
Title	
Surname	
First name	
Persal number	
Id number	
Date of birth	
How long have you been the	e patient's treating medical practitioner?
On which date did you first o	consult with the patient?
On which date did you last o	consult with the patient?

2. EMPLOYEE'S MEDICAL DETAILS

2.1. DIAGNOSIS

2.1.1. What is the nature of the illness/injury from which the patient is suffering? Please indicate the diagnosis (DSM/ICD), if applicable.



2.1.2. What were the presenting symptoms and when did they first appear?
2.1.3. Please detail any co-morbid conditions that will impact on the employee's recovery and incapacity.
2.2. IMPAIRMENT
2.2.1. Describe fully the nature and extent of the physical impairment which resulted in the patient's inability to perform his/her normal duties
2.2.2. Describe fully the nature and extent of the cognitive and /or psychological impairment which resulted in the patient's inability to perform his/her normal duties. (Including MMSE/MoCA if applicable).
2.2.3. In the case of a psychiatric condition, please indicate the GAF at the beginning of treatment and the GAF at review consultations.
2.3. MEDICAL HISTORY
2.3.1. Please detail the onset and history of the illness and/ or injury, including the presenting symptoms.
, , , , , , , , , , , , , , , , , , , ,



2.3.2. Pleas	e provide	details of	ALL consultations	s with the	patient ove	r at least the past	six (6) mont	hs in the t	able below:
Date of consultation			Treatment	Respons					
2.3.3. Please provide details of other medical practitioners' referrals or of hospital admissions over at least the past 3 years.						past 3			
Name of hospital	Reason for admission Date admitted Date dis		scharged Relevant medical practitioner's name Specialit		Speciality		Treatment / surgery		
							1		
2.4 INVEST	ICATION	10							
2.4. INVEST			a finalinana ayah as	ما اممما ام	-t	norto FCC Fabo		. findings	histology
Z.4.1. Please	e detail th	e objective	e findings, such as LUDE COPIES O	S DIOOO TE	Sts, x-ray re	ports, ECG, Echo	cardiograph	y findings,	nistology
		ardiac cor		dicate the	most recen	t ventricular ejecti	on fraction a	and the gra	ading of
2.4.3. In the	case of p	ulmonary	disorders, kindly i	nclude the	e most recei	nt lung function tes	st results.		
2.4.4. In the	case of s	pinal (necl	k and back) condi	tions, kind	dly include la	atest radiology rep	ort.		



2.4.5. In your opinion should the patient undergo further investigations? Please comment.
2.5. TREATMENT
2.5.1. Please provide details of present treatment, i.e. medication (product name, strength, dosage and duration),
rehabilitation, counselling, etc. and how successful they have been.
2.5.2. Please comment on the patient's compliance with and response to all treatment initiated.
2.5.2. Diagon detail any complications or side offeets of treatment are evidenced by the nations
2.5.3. Please detail any complications or side effects of treatment experienced by the patient.
2.5.4. In your opinion could further treatment (e.g. pharmacological / surgical and/or rehabilitation) be beneficial to the
patient.
2.6. PROGNOSIS
2.6.1. What, in your opinion, is the estimated long term prognosis for the patient's condition?



	s the present incapacity temporary or pern ated time period and what is the patient's			ty, please
2.6.3. What is the estim	nated degree of recovery? Kindly tick below	v:		
No recovery	Partial recovery			
2.7. WORK ABILITY				
		Т		<u> </u>
labour related iss ability?	work duties and / or environment and /or sues affect the illness or injury or work	Yes	No	
If yes, please provide de	etails:			
2.7.2. Please comment	on the general mobility of the patient and	indicate if assistive	devices are required.	
2.7.3. In your opinion, i	f the patient is not able to perform his/her	duties, what adapte	ed or alternate duties ar	e possible?
2.8. GENERAL				
	general comments in respect of this patien cation.	t's state of health th	nat will assist in assessi	ing the
1 7 181				



3. MEDICAL PRACTITIONER'S	S DETAILS:			
Surname:		Initials:		
Practice No:		HPCSA Registi No:	ration	
Email Address:		Fax No:		
Address:				
Telephone Number:		Cell phone num	nber:	
DECLARATION I hereby declare and warrant that information has been withheld not be a second to the second			d correct and that no) material
Signed at	on this	Day of	20	
SIGNATURE OF MEDICAL PRACT	TITIONER			



PART E: MOTIVATION OF SUPERVISOR/MANAGER (All fields in this part are mandatory and must be completed)

. JOB DETAILS	OF THE E	MPLOYE	E									
ob Title:					Does the e			e staff	Yes		No	
Prescribed daily ho vork/Average daily		rork			· · · · ·						1	
lature of ppointment	Full-t	time		Fulltime: Shift work Part-time		Contract						
oes this employed erform night shifts						No						
the employee per equested to under ection 17 (3) (b) or een issued and he ttach a copy of the	go a medic f the BCEA ealth related	al examin , 1997 as d issues h	ation in to amended ave been	erms of d? (If a re	eport has	Yes			No	0		
			·								•	
. EMPLOYEE'S												
			E (%) TIN	IE SPEN	IT IN:							
LEASE SPECIFY Total percentage		ITAGE:	TASK		PERC	ENT	AGE:	TASK		PE	RCENT	AGE
	PERCEN							01 ' 1				
Total percentage			Admini	strative				Clerical				
Total percentage ASK lanagerial			Admini Light M					Heavy Ma	anual			
Fotal percentage ASK									anual			



Application Supported		Applicatio	n Not supported			
If not supported please prov	ide reasons for not sup	oporting application	1			
Full Name & Surname of Su	pervisor / Manager:					
Designation						
Tel Number:		Cell Phon	e Number:			
Date:						
Signature of Supervisor/Mar	nager					
DART E. DERORT TO THE L	IF AL TIL DICK MANA	OFD COMPLETE	DV THE HUMAN DE	COUDOEC	DIVICION	
PART F: REPORT TO THE F	1EALTH RISK MANA	JER COMPLETEL	BY THE HUMAN RE	SOURCES	DIVISION	
IMPORTANT NOTES						
The following documentation	must be attached:					
1. A certified copy of employ	ee's Identity Document	(compulsory)				
 Medical report/s (compulse Blood tests, x-ray results, 		pulsory)				
4. Additional written motivati	on (If supplied by empl	oyee)		44 5 44	O4: 5)	
5. PERSAL printout of all leav6. Copies of all sick leave for					Option 5)	
7. Sealed envelope marked for	or the attention of the H					
 A Shift Roster if an employ Medical report issued in te 		of the BCEA. 1997	as amended (if applica	ble)		
1. CONTACT DETAILS OF Name	HR WANAGER OR I	Surnar		<u> </u>		
Designation:		Sumai	116			
Department:			Province		National	
Department address:					1	
Contact number		Work	Alternative			
(Code & no):		Cell phone	Fax no			

Email address:

Signature:

Date:



2. CONTACT DETAILS OF ALTERNATIVE PE	RSON IN HR		
Name and Surname of contact person in departme	nt	Designation	
Contact number (Code & no):	Work	Alternative	Fax no
E-mail address			
3. DECLARATION			
I hereby declare that the information provided i information has either been withheld or omitted		my knowledge true and co	rrect and that no material
Print Name & Surname			
Signature of Head of Department or delegate (as p	er written		Date

PART G: FINAL DECISION BY THE HEAD OF DEPARTMENT (All Fields are mandatory and must be completed)

Ill-health retirement requested	Approved	Not Approved				
COMMENTS/CONDITIONS/INSTRUCTIONS:						
Driet Name						
Print Name						
Signature of Head of Department or		Data				
delegate as per written delegations		Date				
actogate de por mitten actogatione						

FOR OFFICIAL USE

ACTIONS	CAPTURED/EXECUTED	CHECKED & SIGNED OFF
Employee notified of	Name & Surname:	Name & Surname:
decision	Date actioned	Date actioned
Decision captured on PERSAL	Name & Surname:	Name & Surname:
TENOAL	Date actioned	Date actioned
Salary overpayment recovered or Leave	Name & Surname:	Name & Surname:
without pay implemented, (if applicable)	Date actioned	Date actioned
Referred to EHW (if	Name & Surname:	Name & Surname:
applicable)	Date actioned	Date actioned
Referred to Labour	Name & Surname:	Name & Surname:
Relations (if applicable)	Date actioned	Date actioned



APPENDIX 1

MEDICAL INFORMATION FORM IN SUPPORT OF MANDATORY MEDICAL CERTIFICATE (THIS DOCUMENT DOES NOT REPLACE A MEDICAL CERTIFICATE)

(This form must be completed by hand in full by the treating Medical Practitioner)

Dear Medical Practitioner

We would appreciate your co-operation in providing the information requested in this form.

This employee, your patient, has exhausted all of the normal sick leave of 36 working days to which he/she is legally entitled for the entire three-year sick leave cycle, and is now requesting additional fully paid Temporary Incapacity Leave, i.e. additional sick leave. In the context of this consultation, should you decide to recommend the granting of sick leave he/she will be required to apply for Temporary Incapacity Leave for the period in question.

Importantly, such Temporary Incapacity Leave is not a right in terms of the Basic Conditions of Employment Act, (BCEA), 1997 as amended, but is essentially an employee benefit, granted solely at the discretion of the Head of Department. Consequently, as part of the consultation and in terms of paragraph 16.4 of the Rules of the Health Professions Act, 1974, we kindly request that you provide this brief report in addition to the standard medical certificate.

Thank you for taking the time to complete the form.

Name of Employee		
Date (s) of consultation		
Specific symptomatology & severity thereof		
Diagnosis and comorbid conditions		
Objective Clinical findings: (e.g. Blood Pressure, Joint damage, Heart failure, Dyspnoea, Bronchospasm)		
Treatment prescribed also including referral or hospitalisation if applicable		
Response to treatment: (if available)		
Impact of the diagnosed medical condition on the individual's current functional capacity and ability to perform required work tasks		
NAME PRINTED		
QUALIFICATIONS		
PRACTICE NO		
SIGNATURE OF TREATING MEDICAL PRACTITIONER	DATE	