



labour

Department:
Labour
REPUBLIC OF SOUTH AFRICA

Claim Number:

FIRST MEDICAL REPORT IN RESPECT OF AN ACCIDENT
COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (Act No. 130 OF 1993)
[Section 6A(b) – Commissioner's rules, forms and particulars – Annexure 15]

Names and Surname of employee
Identity Number Address:
Postal Code
Name of employer
Address
Postal Code
Date of accident

- 1. Date of your first consultation
2. How did the alleged accident happen?
3. Full clinical description of injury (ies) (not symptoms, signs or syndromes)
4. Describe briefly any pre-existing defect disease
5. X-rays Date By whom
(Attach report if available)
6. Surgical Procedures: Date By whom
Brief description
7. Anaesthetics: General / Local Duration
6. (a) Consultation Yes / No With whom Date
(b) Was the employee referred for physiotherapy? Yes / No Physiotherapist
6. (a) Is the employee unfit for work? Yes / No
(b) Possible date fit for: Light duty Normal duty

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

Signature of Medical Practitioner/Chiropractor
Name (Printed) Date (important)
Address
Postal Code Practice number

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