



BUILDING 2, 1ST FLOOR  
101 CENTRAL STREET  
HOUGHTON  
2041

PRIVATE BAG 87109  
HOUGHTON  
2041

Tel (011) 359-4300  
Fax (011) 359-4302

**FIRST MEDICAL REPORT**

**COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993**

Not to be issued by Practitioner who gives only emergency (single visit) treatment, but by practitioner in permanent charge of case.  
(Reference to the Compensation for Occupational Injuries and Diseases Act, 1993 Medical Handbook will assist in the completion of this form.)

<b>Claim Number</b> _____	<b>Date of Accident</b> _____	<b>Staff number</b> _____
<b>Employer</b> _____		
<b>Employee</b> _____		

1.	a	Time and place of first attendance by you Date _____ Time _____ Place _____
	b	Has employee previously been attended (more than once) for this accident by any other registered medical practitioner (other than your partner or assistant)? * _____
2.		How did the alleged accident happen? _____ _____
3.		Full clinical description of Injury(ies)(precision is essential and the technical terms may be used) Please add additional pages if necessary : _____ _____ _____
4.		In your opinion, is the employee's condition due to the accident described in item 2 above? _____
5.		<b>(Describe briefly any pre-existing defect or disease evident at the time of examination)</b> _____ _____
6.		X RAY EXAMINATIONS: Date _____ By whom made _____ Please attach original or full copy of Radiologist's written report if available
7.		SURGICAL OPERATIONS (including setting of fractures and reduction of dislocations). Date _____ Brief Note _____  ANAESTHETICS:Local or general anaesthetic used? _____ By whom _____ If general please state duration _____ minutes.
8.	a	Have you referred the patient to another medical practitioner? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, to whom? _____ Date _____
	b	Have you ordered physiotherapy? If so, with whom ? _____ Date _____
9.	a	Is the employee unfit for work? <input type="checkbox"/> YES <input type="checkbox"/> NO
	b	On what date, in your opinion is he likely to be fit for Light duty _____ Normal duty _____
10.		Any further remarks _____ _____

**DATE (IMPORTANT):** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

FEDERATED EMPLOYERS' MUTUAL ASSURANCE CO LTD  
1936/008971/06

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