



Claim Number:

***FINAL / PROGRESS MEDICAL REPORT IN RESPECT OF AN ACCIDENT**

(*Delete which is not applicable)

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

[Section 6A (b) – Commissioner’s Rules, Forms and Particulars – Annexure 16]

Names and Surname of Employee _____

Identity Number _____ Address _____

Postal Code _____

Name of Employer _____

Address _____

Postal Code _____

Date of Accident _____

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

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.....

2. Prognosis and further treatment?

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.....

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

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

4. Has the employee’s condition become stabilised? _____

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

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

Signature of Medical Practitioner/Chiropractor _____

Name (Printed) _____ Date (important) _____

Address _____

Practice number _____

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