ANNEXURE H

Employee: Complete Section 1-6 HealthMedical Practitioner: Complete Section 7-9 Please use block capital to complete this questionnaire SECTION 1: PERSONAL DETAILS © Number Police Profesional Public Service Act SECTION 2: PREVIOUS WORK HISTORY Have you been employed by any company other than your current employer where you might have been exposed to vertical Yes ff 'yes', state full details:

MEDICAL QUESTIONNAIRE

united in the Colbridge	Start (year)	End (year)	
1		1-10-01	Type of exposure (e.g. Noise, Chemicals, Astresion)
2			
3			
9			
SECTION 2 HARRYS			

	consent per exp.	Amount per ess	ek:			
	Amount ser day			Type:		
13	What type and amount of alcoholic liquor do you consume?	- que en		Cigars		Pipe
12	if yes, indicate your daily consumption:	County	100	_	No	
11	Have you ever smoked in the past 12 months?		Yes			_

SECTION & FAMILY HISTORY

Have any of your close blood relative ever suffered from heart affects, angine, high blood pressure, strake, disdentes, sugar in the unine, activing, beant failure, cancer, raised cholesterul, mental litress or any other hereditary disease?

Relationship		Apr		Condition	
	Current	At diagnosis	At death	Consider	
other			Al ones		
Aother					
rother					
tier .				A second	

SECTION S. PERSONAL MEDICAL HISTORY

5.1	Disorders of the heart, e.g. rheumatic lever, heart murmurs, pelphations				- 1	Details
	thest pain or discontact (including angles), shortness of breath, cardiac fahire or head attack		Yes	,		
5.2	High Mood pressure, raised cholesterol, (diseases of the Mood vessels) or circulatory discrete:		+	+	-	
5.3	Lung disorder, e.g. Till, Astirma, Chronic branchille, persistent cough or		Yes	N	.	
	wheezing or any other respiratory doorder?			T		
4	Disorders of the dignestive system, stomach, gall bladder, pancreas or		Yes	N		
	liver, e.g. recurrent indigention or hearburn, stomachidusdenal olivers, histus hemia, jaundica, rectal bleeding, pilos, or have ever had gastraecopy, colonoscopy or any special investigation?		Yes	No	F	
5	Diseases or disorders of the kidney, bladder or reproductive organs, e.g. schoromal urine lest, kidney stones, kidney or bladder infections, subjingilla or produstion		Yes	No.	-	
	Any major dental, chiraprantis, optical or geneecological trestment, advice, special investigations, or been hespitalized for these or any			+		
	similar conditions? Revolved actions or treatment in overaction with HNSAIDS or any other		Yes	No		
	sexually transmitted diseases, e.g. hepetils 8, gonorthes, or syphilis?					
	Disorders of the nemous system, e.g. epilopsy or file, blackouts or strains		'es	No		
	Mental discribins, e.g. anxiety, depression, panic attacks, post traumatic stress discribe?		les	No		
	Any tredical ablice, counselling or treatment for alcohol or drug dependency?	7	85	No		
	Ear, eye, nose or throat disorders, e.g. poor vision, pleucome, cataracts,	Y		No		
	hearing lors, ear discharge, hoarseness, post need drip or allergies? Diseases or discriders of the skin, muscles, jointe, limbs, spine, E.g.	Y.	-	No		
	atin resh, eczenia, rheumatism, artivitis, gout, wny other back broable or physical disability?	Ya		lia .		
	Districts, high blood glucces during preparent, thyraid or other harmonel or blood discrete, e.g. setemie, leukemie, Hodgkin's disease, iron deficiency or biereding lendency?	Yes	N			
_	Cancer, greets or tumour of any kind isolating moles removed?	Yes	N	,		
	Any work related disease or injury that was reported to the Compensation Commissioner?					
	If not already mentioned above have you had any other litness or disorder not mentioned above including obvanic Saligue syndrome (Yapole	Yes	No.			
	Rul, Moromarjoja, tropical disease such as bilinarciae or malaria? Famelier: Are you currently programs? If so, when is the expected date of delivery? Date.		-	-		
_	Fernales. Have you ever given birth to a beby weighing more than 4 flig?	Yes	No	- 1		

			0.00
France	Bisons	provide	Section 1
- 200	,	h-made.	PERSON.

,	Any X-ray, ECG or any other investigations or special examinations or had any operation?		T	
1	Taken any medication including anti-depressants, tranquilizers or drugs	Yes	No	
	Including connects (degap), accoine, ecolory, anabolic stansiol, etc. for medical or other reasons?	Yes	No	
	Consulted any disclar or other practitioner, e.g. chiropractor, hamespaths, reflexiologists or iraditional heales/?		+	
	Any routine check-ups or medical examination for insurance purpose?	Yes	No	1.
	Been hospitalised for any medical condition, psychiatric problem or injuries (materially confinement excluded)?	Yes	No	
		Yes	No.	

Doctor's Name	Address	

and warrant that this Personal Statement, whether by my own handwriting or not, is completed in true and understand installament or non-discincere may render invalid any contact of service that may be offered.

Nane	Signature	
		Date

South African Police Services: Operational Response Services: External Deployments

Date

PRE DEPLOYMENT CERTIFICATE OF MEDICAL FITNESS

FAMILY NAME	FIRST NAME (S)
FORCENTO	THOST NAME (S)
FORCE NO.	SA ID No.
Job Title / Rank	
3. Additional tests as indicated / required for the pos	perators / drivers vision test 4. Snellen test st or by the employer
PRE DEPLOYM	ENT FITNESS STATUS
Commensurate with the level of examination requipob description / post / job category the candidate	nested by the employer and or the medical fitness requirements for the incumbent has been found to be:
Fit to work and reside with	hout restrictions or limitations in:
Comments:	III.
Blood Group/Type:	ergies:
The results of this medical are subject to	
The results of this medical are subject to medical	confidentiality and ethical rules.
Signature of examiner:	
STAMP	

ANNEXURE J

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FAO	IAEA													
A CONTRACTOR OF THE		ILO	ITC	ITU	UN	UNDP	UNESCO	UNK	CEF U	NIDO	WHO	WIPO	WMO	l w
CONFIL	DENTIAL	EN	ITRY I	MEDIC	CAL	EXAMIN	NOITA		UNITED	NATIO	VS AND S	SPECIALIZ	ZED AGE	NCI
that a	certify the	at the stat ct statem ble to ler	inmanta				mentioned in ipon my appli questions be al information	form or i						
					Page	s 1 and 2 a	re to be com	nloted by	, the second					
FAMILY NAM	E (IN BLOC	CK CAPITA	ALS)			GIVEN NAME		preced by						
ADDRESS (S	TOFFT TO								MAID	EN NAME	FOR WOME!	(VINCY)	SEX	
ADDRESS (S	IKEET, TO	WN, DIST	RICT OR P	ROVINCE	E, COUN	TRY)			DATE OF BIE	RTH			ПМ	
								t	NATIONALIT	Y				
POSITION AP	PLIED FOR	(DESCRI	BE NATUR	E OF WO	RK)	TELEPHON	E	-	BIRTHPLACE					
DUTY STATIO	DN .					Married [-			Sing	ple 🗆			
							DATE: (d/n			****	7507625	DATE: (d/m/y) DATE: (d/m/y)	*******	
Have you ever Have you ever if so, please st	undergon	wored by	title Unities	7 Namo	the Un	Separated [DATE: (d/m	νy)	?	****	79,7924		*******	
	undergon been emp ale when,	where an	d for whic	h Organ	the Uns or one	Separated [ited Nations of its agen	DATE: (d/m	agencies	?	****	79,7924		*******	
f so, please sta Relative	undergon	where an	d for whic	h Organ	the United States	ited Nations of its agend	DATE: (d/m	agencies RY members ne followin	of your fam	Wido	owed		*******	
f so, please sta Relative	undergon been emp ale when,	where an	d for whice State	h Organ	the United States	ited Nations of its agend	DATE: (d/m	agencies RY members ne followin disord	of your fam	Wide	s No			
Relative	undergon been emp ale when,	where an	d for whice State	h Organ	the United States	ited Nations of its agend	DATE: (d/m	agencies RY members ne followin	of your fam	Wido	s No			
Relative Sther cothers	undergon been emp ale when,	where an	d for whice State	h Organ	the United States	ited Nations of its agend	DATE: (d/m	agencies RY members ne followin disord	of your fam	ily Ye	s No			
Relative Relative ather other others	undergon been emp ale when,	where an	d for whice State	h Organ	the United States	ited Nations of its agend	DATE: (d/m	agencies RY membershe followin disord disord Disease es	of your fam	ily Ye	s No			
Relative Relative ather others sters	undergon been emp ale when,	where an	d for whice State	h Organ	the United States	ited Nations of its agend	DATE: (d/m s or one of its cies? MILY HISTO High 6 Heart (Diabete	RY members ne followin disord Disease es sullosis	of your fam	ily Ye	s No			
Relative sther other others sters	undergon been emp ale when,	where an	d for whice State	h Organ	the United States	ited Nations of its agend	DATE: (d/m s or one of its cies? MILY HISTO Have had th High B Heart (Diabete Tuberc	agencies RY members ne followin disord disord Disease es ulosis	of your fam	ily Ye	s No			
Relative Relative ather others sters	undergon been emp ale when,	where an	d for whice State	h Organ	the United States	ited Nations of its agend	DATE: (d/m s or one of its cies? MILY HISTO Have had th High B Heart (Diabete Tubero Asthma	agencies RY members ne followin disord disord Disease es ulosis	of your fam	ily Ye	s No			
f so, please sta	undergon been emp ale when,	where an	d for whice State	h Organ	the United States	ited Nations of its agend	DATE: (d/m s or one of its cies? MILY HISTO Have had th High B Heart I Diabete Tubero Asthma Cancer Epileps	agencies RY members ne followin disord disord Disease es uulosis	of your fam ng illnesses lers? ssure	ily Ye	s No			
Relative Relative ather other others sters ouse ildren	undergon been emp ale when, Age (if sti alive	where an	State State State deceased	o Nation: h Organ	the Unsor one ization:	ited Nations of its agendance FA	DATE: (d/m s or one of its cies? MMILY HISTO Have had tr High B Heart Diabete Tuberco Asthma Cancer Epileps Mental	agencies RY membersine following disordisordisord President Silver Sil	of your fam ng illnesses lers? ssure	ily Ye	s No			
Relative ather other sters sters ildren	undergon been emp ale when, Age (if sti alive	where an	State State State deceased	o Nation: h Organ of Heal of Heal of Areas	the Unsor one ization:	ited Nations of its agendance FA	DATE: (d/m s or one of its cies? MILY HISTO Have had th High B Heart I Diabete Tubero Asthma Cancer Epileps	agencies RY membersine following disordisordisord President Silvada President Silv	of your faming illnesses lers?	ily Ye	s No	DATE: (diniy)		
Relative ather other sters sters ildren	Age (if sti alive)	where an	State If still afive deceased.	o Nation: h Organ of Heal of Heal of Areas	the Unsor one ization:	ited Nations of its agendance FA	DATE: (d/m s or one of its cies? MILY HISTO High B Heart (Diabete Tuberc Asthma Cancer Epileps Mental (Paralysi	agencies RY membersine following disordisordisord President Silvada President Silv	of your fam ng illnesses lers? ssure TO BE COI OF 1	ily Ye	s No	DATE: (diniy) RECTOR CE	Who?	
Relative ather tother sters TO BE	Age (if sti alive)	where an (i) if (i) if (i) if (ii) if (ii) if (iii) if (i	State State If still alive deceased.	o Nation: h Organ of Heal of Heal of Arrivation	the Units or one ization:	Separated [ited Nations of its agent FA Ag At de	DATE: (d/m s or one of its cies? MILY HISTO High B Heart (Diabete Tuberc Asthma Cancer Epileps Mental (Paralysi	agencies RY members ne followin disord disord disord pres Disease ss ullosis V Disorders is	of your fam ng illnesses lers? ssure TO BE COI OF 1	ily Ye	s No	DATE: (diniy)		
Relative ather tother sters TO BE	Age (if sti alive) COMPLET THE Name of	Where an (i) (i) (if (i) (if (i)	State If still afive deceased.	of Heal of Heal of Heal of Heal of Heal of Heal	the Uris or one ization:	ited Nations of its agent	DATE: (d/m s or one of its cies? WMILY HISTO e had th High B Heart [Diabete Tuberro Asthma Cancer Epileps Mental Paralysi	agencies RY members he followin disord disord Pres Disease es ullosis a Y Disorders is	TO BE COI	ily Ye	s No	DATE: (diniy) RECTOR CE	Who?	

ANNEXURE K

ANNEXURE K:

PART1:

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INFORMED CONSENT TO BE COMPLETED BY THE SERVICE RECIPIENTS PRIOR TO THE COMMENCEMENT OF THE HEALTH AND WELLNESS SCREENING SERVICES

By signing this consent form, you confirm and/or agree that:

- You will be participating in the health and wellness (lifestyle) screening/ assessments consisting of HIV, TB, stress (psychological), BMI, blood pressure, blood glucose, cholesterol, lung function, visual and audiometry.
- You understand the process at which these assessments are being administered following proper explanation.
- You have had an opportunity to ask clarity seeking questions relating to the administration
 of the health and wellness screening/ assessments mentioned above.
- You understand that the abovementioned health and wellness screening/ assessments are entirely voluntary.
- You understand that all the tests which will be administered on you are only for screening purposes and NOT provide diagnosis. Furthermore, you understand that additional confirmatory tests may be required to conclude the diagnostic process.
- A few drops of blood will be collected from you through a finger prick. A finger prick may cause some short-term discomfort such as pain, numbness and/or swelling or other complications.
- An HIV pre-test counselling has been provided to you and that you are aware that subsequent to the results being made available to you, an HIV post-test counselling has to be provided.
- At the age of eighteen (18) years and above, you have the legal capacity to give informed consent and in a position to fully understand and make decisions about the management of your health and wellness.

I hereby declare that I have read and understood the abovementioned information and give consent that the described health and wellness screening/ assessments be provided to me:

Name (in print) of the service recipient	Signature	Date

PART2:

Other, please specify:

INFORMED CONSENT TO BE COMPLETED BY THE SERVICE RECIPIENTS FOR REFERRAL FOLLOWING HAVING RECEIVED ABNORMAL SCREENING RESULTS

We understand that you have just received abnormal health screening result(s) and we would like to support you in the management of your health condition(s) by providing you with more information. If you would like to receive further support, a specialized case management consultation will be arranged for you within three (3) to five (5) working days. You will therefore receive a telephone call from a case management officer who will provide you with counselling and further information relating to your health condition.

By completing the section below and signing this consent form, you consent to your test results being disclosed to a team of selected case management specialists who will be contacting you by telephone for a further discussion.

Date	:		
First name	:	*********	
Surname	:		
Contact number	:		
Best time to call	:	&	
Medical scheme	:	_	
Medical aid number :			
Reason for referral			
wedson for referral	HIV management/ support:	YES	NO
	Registration on the Disease Risk Management (DRM) Programme		
	TB management/ support	YES	NO
	Registration on the Chronic Risk Management (CRM) Programme		
	Psycho-social support	YES	NO

By signing this referral consent form, you confirm and/or agree that:

- I hereby confirm that the information provided in this consent form is true and correct.
- I hereby give consent that (name of the Health Risk Manager) may forward my health screening results and contact details to my medical aid scheme. I also give consent that a case management officer may contact me concerning my results.
- I understand NO information regarding my case will be made available to my employer or any other person not directly involved in my health care.
- I understand that telephone calls will be recorded for medical scheme's internal clinical quality assurance purposes.

I acknowledge that my details provided in this referral consent form are treated with absolute confidentiality and I accept that my medical scheme may use these details only to communicate with me.

Signature of the service recipient

ANNEXURE L:

A LIST OF THE HEALTH AND WELLNESS SCREENING SERVICES

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- 1. HIV Counselling and Testing (HCT)
- 2. TB Risk Assessment (Self-reported Questionnaire)
- 3. Psychosocial [Stress] Assessment (Self-reported Questionnaire)
- 4. Health Risk Assessments (HRA Clinical Risk Assessment)
- 4.1 Body Mass Index (BMI) and Waist Circumference [to determine obesity]
- 4.2 Blood Pressure

[to assess hypertension]

4.3 Blood Glucose

[to assess diabetes]

- 4.4 Cholesterol
- 5. Client Satisfaction Survey

HEALTH AND WELLNESS SCREENING/ ASSESSMNETS TARGETS FOR 2024/2025 HIV TESTING AND COUNSELLING (HCT)

HEALTH RISK ASSESSMENTS (HRA)
DIVISION: HUMAN RESOURCE MANAGEMENT

COMPONENT: EMPLOYEE HEALTH & WELLNESS SECTION: QUALITY OF WORK LIFE

HIV COUNSELLING AND TESTING (HCT)

WESTERN CAPE 22 647 EASTERN CAPE 22 094 NORTHERN CAPE 8120	MATE	(20% OF THE TOTAL ESTABLISHMENT)	UL APRIL 2024 - 31 MARCH 2025
J.		5 319	(2707)
Į.	47		1330
J.	0.4	4 529	4
	***	4410	1 132
		6144	1 105
	50	1624	200
FREE STATE	67	641.6	406
KWA-ZULI NATAL		2 /53	6 88
27 291	91	5 458	
NORTH WEST			1 365
/6T FT	/+	2 229	557
MPUMALANGA 11 223	23	2 245	
LIMPOPO			561
13 616	TP	2 723	203
GAUTENG	00		180
	20	7 360	1840
TOTAL 193 296	960	1	2
		38 659	9 665

ANNEXURE N

HEALTH AND WELLNESS SCREENING/ ASSESSANETS TARGETS FOR 2024/2025 HIV TESTING AND COUNSELLING (HCT) COMPONENT: EMPLOYEE HEALTH & WELLNESS DIVISION: HUMAN RESOURCE MANAGEMENT HEALTH RISK ASSESSMENTS (HRA) SECTION: QUALITY OF WORK LIFE

GENERAL HEALTH RISK ASSESSMENTS (HRA)

HEAD OFFICE DIVISIONS	30 IIINE 2023	HRA TARGETS TO BE TESTED BY	OliabTEDIVUCTTA
HEAD OFFICE DIVISIONS	TRASELINE ESTIMATES!	31 MARCH 2025	[01 APRIL 2024 - 31 MARCH 2025]
	26 593	7 070	
WESTERN CAPE	22 647	0161	1 995
EASTERN CAPE		6 794	1 699
THE CONTRACTOR OF THE CONTRACT	22 094	6 628	1,657
NORTHERN CAPE	8 120	2 436	/ CO T
FREE STATE	13 767	7 430	609
KWA ZIIII MATA	/8/ ST	4 130	1033
WA-ZULU NAIAL	27 291	00100	
NORTH WEST	1000	6010	2 047
	11 147	3 344	200
MPUMALANGA	11 223	736.6	836
LIMPOPO	12.616	1000	842
A Limited	9T9 ST	4 085	1031
GAUTENG	36 798	11 020	1707
TOTAL		11 039	2 760
	193 296	57 989	14.497

ANNEXURE O

SAPS 652 (A)

CONFIDENTIAL

SOUTH AFRICAN POLICE SERVICE



APPLICATION FORM:

TEMPORARY INCAPACITY LEAVE SHORT PERIODS

(Period from 1 to 14 working days)

SAPS 552 (A)

IMPORTANT

- This application form must be completed in respect of a period of temporary incapacity leave of less than 15 working days.
- Please note that an employee must proof to the satisfaction of the Service that he or she is incapable of performing work as a result of an illness or injury.
- 3. In keeping with the principles contained in item 10 of Schedule 8 of the Labour Relations Act, 1995, this application affords the employee the opportunity to submit medical evidence relating to his or her medical condition (such as medical reports from a specialist, blood tests results, x-ray results, results from scans, etc.) or any other motivation which he or she deems relevant and in support of his or her application and which the employee believes that the employer should take into account when considering his or her application for temporary incapacity leave.
- Please ensure that this form is fully completed, signed and accompanied by all
 the necessary documentation. An incomplete form or the absence of the
 necessary supporting documentation will delay the finalization of the application.
- An investigation in terms of National Instruction 2/2004 may be conducted in respect of this application.
- Please note that if this application is declined, the period of absence will be converted to either annual leave, capped leave or unpaid leave.
- This application form and supporting documentation is classified as "Confidential".

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CONFIDENTIAL

AUTHORIZATION

	ID No	
person to as "the Employer") hereby authorize/re any medical practitioner, hospital, institution, clir may hold any medical records relating to me or release to the Employer any and all details and in relating to any illness, ir.jury or condition including (including blood and other tests), x-rays, records reports and summaries, correspondence between provided treatment or where I have been a patie of any nature whatsoever.	e of the South African Police Service (hereinal fuse to authorize (delete whichever is a nic, health care provider or any other relevant any treatment or advice provided to me, to formation, specifically including confidential is g, without limitation, all clinical records, tabora of all prescribed medications and treatment on my medical practitioner and any other persent or from whom I have received any medical price (detete whichever is not applicable) the Edanager any and all information referred to ab	fier referred to applicable person the furnish an information story result as, progress on who had treatment to the property of the property o
as any other information that may be in the poss for temporary incapacity leave, medical reports, further authorize/refuse to autho Manager to disclose and make available any of	ession of the Employer, including previous a lob descriptions and specifications and relate FIZE (delete whichever is not applicable) the H	pplications ed records
Linksoyer.		
confirm that a photocopy of this authority shall		0
confirm that a photocopy of this authority shall is signed at	day of 2	0
confirm that a photocopy of this authority shall i	day of 2	0
confirm that a photocopy of this authority shall is signed at	m on his or her behalf	0
confirm that a photocopy of this authority shall is signed at	m on his or her behalf	
confirm that a photocopy of this authority shall is signed at	m on his or her behalf	
confirm that a photocopy of this authority shall is signed at	m on his or her behalf Date Code	
confirm that a photocopy of this authority shall is signed at	m on his or her behalf	0
confirm that a photocopy of this authority shall is signed at	m on his or her behalf Date Code	



SAPS 552 (A)

OCHUMA ACI	143.040	nei	-	en errore.	M-STATE
SOUTH AF	NF-ARM	ru.	ᄣ	SERV	INCE

(3)

SUID-AFRIKAANSE POLISIEDIENS

Reference	SAPS	Prov/Div	НО	Town of some	CHAINFORN THE TOWNS		
number	Gre G	PIONDIA	no no	Type of application Short term			
First date of 2006/05/17	absence,	eg	PERS	AL number	Authorization number(s)		
					1		

PART 1 To be completed by the employee

Personal particulars

PERSAL number			Rank		
Component/Section/Station/Unit					
Job title					
Surname					
First names					
Identity number					
Date of birth			Age	1	
Date of appointment			Already on sick leave	Yes	No
Selery tevel			Date of last day at work		10000
Pension fund			Date duty resumed	1	
Shift worker	Yes	No	Gender	5.0	F
is the injury or linees the result of on injury on duty (ICO)?	Yes	No	WYes - Regulation 68(1)	(a) applies	Vision (A

R Contact details

o. Cumou du	ens ;		
4-25	W		
HOME ADDRESS			
ADDRÉSS DURING			
ABSENCE FROM WORK			-
Tet. number	Office	Home	
Fax number		Cell	
E-mail		Other contact	

2008-01-04

CONFIDENTIAL

Page 4 of 11

CONFIDENTIAL

		disease/incapacity (brief description)	
App	plication for te	mporary incapacity leave	
Pt	eriod	Injury/disease/incapacity (Description/diagnosis)	Medica
Start date	End date	2000年1月1日 - 1000年1月1日 - 1000年1月 - 1	Yes / N
-)	
Deta	ills of occupati	ion	
De		rent duties and functions	
Dos	oribe the physic	cal demands of the job	
Des	oribe the physic	zil demends of the job	
Des	cribe the physic	zel demands of the job	
23 80 5		demands of the job	
23 80 5			
Desc	aribe the mental		
Desc	aribe the mental	demands of the job	

CONFIDENTIAL

77.77		our highest level of educati		TARKS	Call Carry Miles
В.	Are you po	offorming other remembration	re work? If yes, d	escribe as you have in E1 o	p to E4 on a separate foli
D	etalis of in	ncapacity			
1	Describe ti	no injury / disease that has	given rise to this	application (only one)	
		edical consultation in relati	on to this applicat	ion	
terne of doo pecialist	clor			Date of first consultation	
	-			Tel ne	
ddress					
nte of test o	2/9/	Astronomic Control	skith professions		
nte of test of Deta trica	2/9/	tore, specialists, other he	10145.45	is and hospitals you have	I see a see
Deta Inca	alts of docs	Astronomic Control	eith professions Specially	is and hospitals you have	consulted pertaining to
Deta Inca	alts of doct pacity	tore, specialists, other he	10145.45		I see a see
II riceriani	alts of doct pacity	tore, specialists, other he	10145.45	Address & tel. no	I see a see

CONFIDENTIAL

PL.	Details of the impact of your health condition on your work performance and other functions and the practic implications of your injury / disease on the following activities of delly life
1.	Describe the specific difficulties you are experiencing in performing your duties, including those relating to other remunerative work, if any
2	Mobility (standing, walking, banding, carrying, etc.)
3	Self-cere (esting, dressing, bathing, etc.)
4	Management at home (domestic chores, gardening, shopping, home maintenance, etc.)
(820)	Transport (driving, use of public transport, etc.)
1333	Sport and recreational activities

CONFIDENTIAL

SAPS 552 (A)

Declaration by employee

I hereby declare and warrant that the information given 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 do 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.

Indemnity

I hereby indemnify the Employer against any claim of whatever neture, which may be made against them as a result of, or arising from the furnishing of any information as provided for herein.

applicant is incapsolated	The state of the s	MANAGER AND ASSESSED IN THE	4.9-175、3F5 (自由等)
Signature of witness If	Print name	Rank	Date
employee is incapacitated			
Signature of person completing this form if the employee is incapacitated	Print name	Rank	Dete
	Print name	Renk	Date

CONFIDENTIAL

SAPS 552 (A)

PART 2 Statement by employer

A. Details of contact person in the Service (commander/supervisor)

Initials & Sumarno	./4		
Post title			
Rank			THE CONTRACTOR OF THE PARTY OF
	Station		
Physical address	Component		
	Province/Division		
Postal address	S .		
		Postal code	
Tel number	of the second se	e-mail address	
Fax number	A 100	Cell	

 Employee's sick leave record for the current and previous sick leave cycle as compiled by the relevant Provincial or Divisional office.

	Period	105-21/12/2005	Injury/disease/incapacity (Description/diagnoses)	Medical	certificati
Start date	End date	No of working days	(Description/diagnoses)	Yes	No
				-	-
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to	scribe any other perform his/her (futies satisfacto	LINE OF OUR	side work, whit	th could be cont	infouting to the e	mployee's diff	icelties
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SAPS 552 (A)

D. Compulsory	Documents	to be	Attached
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D.	Compulsory Documents	to be Attached		
Attac	fuments		5 . 6 . 6 . 6 . 1 . 1 . 1	Tick ₹
	SAPS 47 (previous & cu	ment sick lesve cycle)	SC 11 C 3 S	7.32
	Modical certificate(s) CO	MPULSORY WITH SPECIFIED D	IAGNOSES	
•	Current Medical reports for	rom specialists (Not older than 6 n	nonths, if applicable)	
. /	- 1 40 X PA 30 Y PRINCE SAFOREMENT IN	PSYCHOLOGICAL & TERMINALI	THE R. LEWIS CO., LANSING, MICH. 491-1403-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	
•	Commander's report (OP	TIONAL)		
	Certified copy of Per 4.5.	11, indicating that this temporary in	ncapacity leave has been capture	d
	10 DOZDONE DOZIO A 47 LIZBA	ts (example: X-ray reports) (OPTIC	NAME AND ADDRESS OF TAXABLE PARTY.	17.4.**
	Additional written motivati	A CONTRACTOR OF THE PARTY OF TH	V-1-1-1-1	
njuryd	Illness on duty/Arese out of	f the performance of official duti	les	70
1	SO 125 / Convening order	in terms of Regulations 5(1) & 66	(1)(a)	2
145	SAPS 114	是14年10月16年。11	THE PARTY OF THE P	3
	WCL 2 (Employer' Report			25
	WCL 4 (First Medical Rep	ort)		
	WCL 303 & WCL 304 in cr	ases of PTSD	The same	N. Control
	Statement by employee			R
	Statement by commanded	supervisor (on/off duty during incid	ient)	12 P
N.	Statement by person to wh	om injury/filness was reported first	I SAFA	
	Statement(s) by eye witnes	s(es)	2000年1000年100日	1
	of the employee concerned w	mation given is factual, true and oor es emitted. the commander	r/supervisor hereby also certifies	that the leave recon
	Initial & Sumame	Signature	Rank	Date

Initial & Surname	Signature	Renk	Date
		1	

Temporary incapacity leave application <u>and</u> captured pending temporary incapacity leave on Persal verified by the office of the relevant Divisional or Provincial Commissioner. F.

Initial & Sername of perueing officer	Signature of perusing officer	Date

ANNEXURE P

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CONFIDENTIAL

SOUTH AFRICAN POLICE SERVICE



APPLICATION FORM:

TEMPORARY INCAPACITY LEAVE SHORT PERIODS

(Period from 15 to 29 working days)

2008-01-04

CONFIDENTIAL

Page 1 of 13

CONFIDENTIAL

SAPS 552 (B)

IMPORTANT

- This application form must be completed in respect of temporary incapacity leave for a period of 15 working days or more but less than 30 working days.
- Please note that an employee must proof to the satisfaction of the Service that he or she is incapable of performing work as a result of an illness or injury.
- 3. In keeping with the principles contained in item 10 of Schedule 8 of the Labour Relations Act, 1995, this application affords the employee the opportunity to submit medical evidence relating to his or her medical condition (such as medical reports from a specialist, blood tests results, x-ray results, results from scans, etc.) or any other motivation which he or she deems relevant and in support of his or her application and which the employee believes that the employer should take into account when considering his or her application for temporary incapacity leave.
- Please ensure that this form is fully completed, signed and accompanied by all
 the necessary documentation. An incomplete form or the absence of the
 necessary supporting documentation will delay the finalization of the application.
- An investigation in terms of National Instruction 2/2004 may be conducted in respect of this application.
- Please note that if this application is declined, the period of absence will be converted to either annual leave, capped leave or unpaid leave.
- This application form and supporting documentation is classified as "Confidential".

SAPS 552 (B)

AUTHORIZATION

1	ID No
PERSAL Noan employ	yee of the South African Police Service (hereinafter refen
to as "the Employer") hereby authorize/	refuse to authorize (delete whichever is not applicat
any medical practitioner, hospital, institution, of may hold any medical records relating to me release to the Employer any and all details and relating to any illness, injury or condition includ (including blood and other tests), x-rays, recording to any illness, correspondence between	clinic, health care provider or any other relevant person to or any treatment or advice provided to me, to furnish a dinformation, specifically including confidential information, ling, without limitation, all clinical records, laboratory resurds of all prescribed medications and treatments, progre seen my medical practitioner and any other person who has tient or from whom I have received any medical treatments.
as any other information that may be in the po	horize (delete whichever is not applicable) the Employer Manager any and all information referred to above as was seession of the Employer, including previous application s, job descriptions and specifications and related record
I further authorize/refuse to auth	OFIZE (delete whichever is not applicable) the Health Ris
Manager to disclose and make available any of Employer.	of the aforementioned information in its possession to the
I confirm that a photocopy of this authority sha	
Signed at on this the	day of
Employee or other person completing the fo	orm on his or her behalf
Signature of witness 1	Date
Full Name & Surname:	
Tel No.:	Code
	Code
Cell No.:	
Cell No.: Signature of witness 2	Code
Tel No.: Cell No.: Signature of witness 2 Full Name & Surname: Tel No.:	

SAPS 552 (B)

CONSENT TO UNDERGO MEDICAL EXAMINATION

I acknowledge that for the employer to consider and evaluate any application for incapacity or ill health benefits, I may be required to undergo a medical or psychological evaluation and other tests including, without limiting the generality of the afore-going, 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 after 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 attached to my non-keeping of the appointment from me.

I undertake to present myself for any appointment timely 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 on 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 an whatever nature, which may be made against them as a result of, or arising furnishing of any information as provided for herein.	from the
Signed at on this the day of	20

Employee or other person completing the form on his or her behalf

Signature of witness 1	Date	
Full Name & Surname:		
Tel No.:	Code	
Cell No.:		
Signature of witness 2	Date	
Full Name & Surname:	1	
Tel No.:	Code	
Cell No.:		

SAPS 552 (B)

SOUTH AFRICAN POLICE SERVICE

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SUID-AFRIKAANSE POLISIEDIENS

First date of absence, eg PERSAL number Authorization number(e)	ACCOMPANY NAMED IN COLUMN TWO IS NOT THE OWNER.	Reference SAPS Prov/Dlv number		НО	HO Type of application					
	number				Short term	The state of the s				
2005/05/17	First date of 2006/05/17	absence,	eg	PER	SAL number	Authorization number(s)				

PART 1 To be completed by the employee

A. Personal particulars

PERSAL number			Rank		
Component/Section/Static+/Unit		110 00 000 100 100	-		
Job title					
Sumame					
First names					
identity number					
Date of birth			Age		
Date of appointment			Already on sick leave	Yes	No
Salary lovel			Date of fast day at work		
Pension fund			Date duty resumed		
Shift worker	Yes	No	Gender	M	F
is the injury or litness the result of an injury on duty (IOD)?	Yes	No	If Yes - Regulation 68(1)	(a) applies	

B. Contact details

HOME ADDRESS			
ADDRESS DURING ABSENCE FROM WORK			
Tel number	Office	Home	
Fax number		Cell	
E-mail		Other contact no	

SAPS 562 (B)

Application for temporary incapacity leave

Pe	boine	Injury/disease/incapacity (Description/diagnosis)	Medics certifica
Start date	End date		Yes / N
). Det	alfs of occupation		
	scribe your current duties a	nd functions	
2 De	scribe the physical demands	s of the job	
Des	sorbe the mental demands o	of the job	
Des	cribe the tools, equipment a	nd meterials used to perform the job	Ale Say
Indio	tale your highest level of edi	scetion	
Arey	rou performing other remun	eretive work? If yes, describe so you have in E1 up to E4	on a seperate folio

CONFIDENTIAL

SAPS \$52 (B)

	TORCH NAME	WITH THE PARTY OF THE PARTY.	1170000		
0.7	Describe th	o injury / disease that has gi	von rise to this appl	cetion (only one)	
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-					
-			-		-
251	Datalla of m	edical consultation in relation			
ime of	THE RESERVE AND ADDRESS OF THE PARTY OF THE	Werder Consolication at research		o of first consultation	
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			Tel	(R)	-
dress			March law states to the processing a		
te of la	st consultatio	on .			
100		56 (0.00) (25 (0.00))			
D	etails of doc	tors, specialists, other hea	ith professionals a	nd hospitals you have o	consulted pertaining to
	Period	ctors, specialists, other hea	ith professionals a	nd hospitals you have o	Treatment received
		Telephone and the second			
	Period	Telephone and the second			
	Period	Telephone and the second			
	Period	Telephone and the second			
rom	Period To	Doctor/hospital/other	Speciality	Address & tel. no	Trestment received
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rom	Period To Details of other	Doctor/hospital/other	Speciality	Address & tel. no	Trestment received
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rom	Period To Details of other	Doctor/hospital/other	Speciality	Address & tel. no	Trestment received
rom	Period To Details of other	Doctor/hospital/other	Speciality	Address & tel. no	Trestment received
rom C	Period To Details of othe incepacity	Dector/hospital/other er concurrent or past injuries	Speciality Missesses/linesses	Address & tel. no	Treatment received
From	Period To Details of othe incepacity	Doctor/hospital/other	Speciality Missesses/linesses	Address & tel. no	Treatment received
Prom Com	Period To Details of other respectly talls of the implications of	Declar/hospital/other er concurrent or past injuries meact of your health condit your injury / disease on the	Speciality Idiscesses/linesses	Address & tel. no which in your opinion may performance and other tes of daily life	Treatment received y have contributed to you
Prom Com	Period To Details of other respectly talls of the implications of	Dector/hospital/other er concurrent or past injuries	Speciality Idiscesses/linesses	Address & tel. no which in your opinion may performance and other tes of daily life	Treatment received y have contributed to you
Det Imp	Period To Details of other respectly talls of the implications of	Declar/hospital/other er concurrent or past injuries meact of your health condit your injury / disease on the	Speciality Idiscesses/linesses	Address & tel. no which in your opinion may performance and other tes of daily life	Treatment received y have contributed to you

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Self-care (eating dressing bathing etc.)
Management at home (domestic chores, gardening, shopping, home maintenance, etc.)
Transport (driving, use of public transport, etc.)
Sport and recreational activities

CONFIDENTIAL

SAPS 552 (B)

H. Declaration by employee

I hereby declare and warrant that the information given 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 do 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.

Indemnity

I hereby indemnify the Employer against any claim of whatever nature, which may be made against them as a result of, or arising from the furnishing of any information as provided for herein.

Ilgnature of person			-
completing this form if the implayee is incepecitated	Print name	Rank	Date
ignature of witness if applicant is incapacitated	Print name	Renk	

CONFIDENTIAL

SAPS 552 (B)

PART 2 Statement by employer

A. Details of contact person in the Service (commander/supervisor)

Initials & Sumame			
Post title			
Rank			
	Station		
Physical address	Component		
	Province/Division		
Postal address			
		Postal code	
let number		e-mail address	
ex number	D	Cell	

B. Employee's sick leave record for the current and previous sick leave cycle as compiled by the relevant Provincial or Divisional office.

	Period		Injury/disease/incapacity (Description/disgnoses)	Medical certificate	
Start date	End date	No of working days	(Description/disgnoses)	Yes	No
				-	1000
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					1
					1
					1
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-		-			
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				1	

		SAPS 552
MARKET OF HIGHE		
RECOMMENDATIONS)	EMPLOYEE'S PERFORMANCE (NO	MEDICAL COMMENTS
Describe the broad of the initiation		
environmental factors	ase on the employee's work abilities, with refer	rence to specific work duties en
		-
Describe any other factors, either at w	and or outside used while the	
to partorn his/her duties satisfactorily	vork or autside work, which could be contribute	ing to the employee's difficulties
		the state of the s
	the state of the s	
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CONTRACTOR OF THE PROPERTY OF STREET AND THE PROPERTY OF STREET, STREE	date the employee's Impairment/incapacity by	advantage the same to the
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Was the employee referred to the EAS?		
Was the employee referred to the EAS?	7 3 2 2 3 3	

CONFIDENTIAL

SAPS 552 (B)

D. Computerry Documents to be Attached

PAG	is chateres.	Tick √
×	SAPS 47 (previous & current sick losve cycle)	
	Medical cartificate(s) COMPULSORY WITH SPECIFIED DIAGNOSES	
	Current Medical reports from specialists (Not older than 6 months, if applicable)	
	EAS report (ONLY IN RESPECT OF PSYCHOLOGICAL AND TERMINALLY ILL CASES)	
	Consmandor's report (OPTIONAL)	1
	Minutes of censer discussion	
	Supportive colleteral information (OPTIONAL)	
	Copy of identification document of the employee	-
	Certified capy of PERSAL 4 5 11, indicating that this temporary incapacity leave has been captured	
	All relevant medical reports (example: X-ray reports) (OPTIONAL)	
	Additional guittien motivation (OPTIONAL)	
n/se	ryAllness on dutylerisen out of the performance of official duties	2910200
	SO 125 / Convening order in terms of Regulations 5(1) & 66(1)(a)	
100	SAPS 114	
	WCL 2 (Employer Report)	
	WCL 4 (First Medical Report)	
	WCL 303 & WCL 304 in cases of PTSD	
	Statement by employee	
	Statement by commander/supervisor (on/off duty during incident)	
	Statement by person to whom injury/filmess was reported first .	
	Statement(s) by eye witness(es)	
	Declaration by commander/supervisor I hereby declare that the information given is factual, true and correct, and that no material information nor any relevant circumstances omitted.	
	the commander/supervisor hereby also certifies that	the leave records
	of the employee concerned was verified by me on and that all absence on Persal, including the periods of temporary Incapacity leave applied for in this application. Persal by me and the SAPS 47 and Persal 4.5.11 do correspond.	has been captured I.5 11 was verified

Signature	Rank	Date
		1
	Signature	Signature Rank

CONFIDENTIAL

SAPS 552 (B)

F. Temporery incapacity leave application <u>and</u> captured pending temporery incapacity leave on Percal verified by the office of the relevant Divisional or Provincial Commissioner.

initial & Surname of perusing officer	Signature of perusing officer	Date

SAPS 552C

SOUTH AFRICAN POLICE SERVICE 201



APPLICATION FORM:

LONG TERM TEMPORARY INCAPACITY LEAVE (Period longer than 29 working days)

OR

ILL-HEALTH RETIREMENT

IMPORTANT

- This application form must be completed in all instances where the medical evaluation has been initiated by the Employer.
- An employee must provide the Employer with all necessary medical reports and/or certificates to enable the Employer to conduct the said functional medical evaluation.
- 3. In keeping with the principles contained in item 10 of Schedule 8 of the Labour Relations Act, 1995 read in conjunction with "Policy on Incapacity Leave and III-Health Retirement in the Public Service", this medical evaluation serves to determine the nature and extent of the employee's functional impairment as a result of iII-health.
- 4. Please ensure that this form is fully completed, signed and accompanied by all the necessary medical documentation as well as any other material report(s) of relevance such as EHW report and Commander's report. An incomplete form or the absence of the necessary supporting documentation will NOT be accepted.
- 5. All information entered into this form is classified as "Confidential".

Signature of witness 2

Full Name & Surname:

Tel No .:

I hereby certify that I have read the above	and understand the contents thereof.	
Signed at on this the	day of	
Employee or other person completing t	the form on his or her behalf	
Signature of witness 1	Date	
Full Name & Surname:		
Tel No.:	Code	
0-1111		

Date

Code

AUTHORIZATION

referred to as "the Employer") hereby authorize applicable) any medical practitioner, hospital, institution health care provider or any other relevant person that any treatment or advice provided to me, to furnish an information, specifically including confidential information, without limitation, all clinical records, labor rays, records of all prescribed medications and correspondence between my medical practitioner and where I have been a patient or from whom I have whatsoever.	on, Polmed or any other medical scheme, clinical may hold any medical records relating to me of release to the Employer any and all details an nation, relating to any illness, injury or condition ratory results (including blood and other tests), x treatments, progress reports and summaries dany other person who has provided treatment of
I hereby authorize/refuse to authorize disclose and make available to the Health Risk Manawell as any other information that may be in the papplications for temporary incapacity leave, medical related records. I further authorize/refuse to authorize Manager to disclose and make available any of the aformation authorize authorize.	ager any and all information referred to above as possession of the Employer, including previous reports, job descriptions and specifications and (delete whichever is not applicable) the Health Risk
I confirm that a photocopy of this authority shall be as	effective and valid as the original.
Signed at on this day of .	20
Signed at on this day of . Employee or other person completing the form on I	
Employee or other person completing the form on I	his or her behalf
Employee or other person completing the form on I	his or her behalf Date
Employee or other person completing the form on I Signature of witness 1 Full Name & Surname:	his or her behalf
Employee or other person completing the form on I Signature of witness 1 Full Name & Surname: Tel No.: Cell No.:	Date Code
Employee or other person completing the form on I Signature of witness 1 Full Name & Surname: Tel No.:	his or her behalf Date
Employee or other person completing the form on I Signature of witness 1 Full Name & Surname: Tel No.: Cell No.:	Date Code

CONSENT TO UNDERGO MEDICAL EXAMINATION

I acknowledge that for the employer to consider and evaluate my functionality, I may be required to undergo a medical or psychological evaluation and other tests including, without limiting the generality of the afore-going, blood tests for the purpose of determining the nature, extent and relevant treatment for any medical condition 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 after 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 expenditure incurred as a result of my non-attendance to the scheduled medical appointment(s).

I undertake to present myself for any appointment timely 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 on 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 of whatever nature, which may be made against them as a result of, or arising from the furnishing of any information as provided herein.

.....

Signature of witness 1	Date
Full Name & Surname:	
Tel No.:	Code
Cell No.:	
Signature of witness 2	Date
Full Name & Surname:	
Tel No.:	Code
Cell No.:	



SOUTH AFRICAN POLICE SERVICE



SUID-AFRIKAANSE POLISIEDIENS

For office use only	

Reference	SAPS	Prov/Div	НО	Type of applic	cation
number				(Full Functional Assessment)	
First date of 2006/05/17	absence,	eg	PERS	SAL number	Authorization number(s)

PART 1 To be completed by the employee

 Personal particulars 						
PERSAL number	6		Rank			
Division / Province						
Component/Section/Station/Unit						
Job title						
Surname						
First names						
Identity number			Age			
Date of birth			Already on sick leave	Yes	No	
Date of appointment		15	Employment Category Act	Police Act	Pub	lic Service Act
Salary level			Date of last day at work			
figher/Academic Qualifications						
Pension fund			Date duty resumed			
Shift worker	Yes	No	Gender	M	F	
s the injury or illness the result of in injury on duty (IOD)?	Yes	No	If Yes - Regulation 68(1)(a) applies			

B. Contact details

HOME ADDRESS	
Barrier and State of the State	
ADDRESS DURING ABSENCE FROM WORK	

Tel. number	Office	Home	
Fax number		Cell	
E-mail		Other contact no	



C. Nature of application

	application
Reason for applica	tion Brief description of injury/disease/incapacity
Full functional medic Assessment initiated Employer	
). Details of o	occupation
Describe ye	our current duties and functions
. Describe the	e physical demands of the job
Describe the	mental demands of the job
Describe the t	tools, equipment and materials used to perform the job
Indicate your h	nighest level of education
	ming other remunerative work? If yes, describe as you have in E1 up to E4 on a separate folio.
Are you perform Details of incap	



Name of do	octor			Date of first consultation	
Specialist				Tel no	
Address				AND DESCRIPTION OF THE PARTY OF	
		LA CONTRACTOR			
Date of last	consultation				
Det	tails of docto apacity	rs, specialists, other healt	h professionals a	nd hospitals you have cor	nsulted pertaining to
1. Pe	eriod	Doctor/hospital/other	Speciality	Address & tel. no	Treatment receive
From	То			1.00.000 0 101.770	rreaument receive
. Det	ails of other co capacity	oncurrent or past injuries/dis	seases/illnesses wi	nich in your opinion may ha	ve contributed to your
Detail Implie	s of the impa	act of your health condition or Injury / disease on the f	n on your work pe following activities	erformance and other fund s of daily life	ctions and the practic
Detail Implic Desc rem	s of the impa cations of you cribe the speci	act of your health condition or Injury / disease on the f	n on your work pe following activities lencing in performi	erformance and other fund s of daily life	ctions and the practic
Detail Implication	s of the impa cations of you cribe the speci nunerative wor	nct of your health condition or injury / disease on the f fic difficulties you are expert k, if any.	n on your work pe following activities lencing in performi	erformance and other fund s of daily life	ctions and the practic

Management at home (dome	estic chores, gardening, shopping, hon	ne maintenance, etc.)	
. Transport (driving, use of pub	lic transport, etc.)		
Sport and recreational activities	s		
Any falsification of informal understand that the buafforded the opportunity effect with this application	rrant that the information give tion has been withheld or ar mation in this regard may found or proof of my illness/ to submit additional medical on. I do understand that if I formation	ny relevant circumstance rm grounds for disciplin injury rests with me and al evidence and motival	es omitted. eary action. d that I am tion to this
I hereby indemnify the El	mployer against any claim of result of, or arising from the Print name	of whatever nature, which e furnishing of any information Rank	ch may be mation as
gnature of person completing s form if the employee is apacitated	Print name	Rank	Date
nature of witness if applicant			1
capacitated	Print name	Rank	Date

PART 2 Statement by employer

A. L	etails of contact person in the Sei	rvice (commander/supervisor)	
Initials & S	urname		
Post title			
Rank			
	Station		
Physical address	Component		
	Province/Division		
Postal addr	ess		
0.20		Postal code	
Tel. number	Section 1995	e-mail address	
Fax number		Cell	

B. Employee's sick leave record for the current and previous sick leave cycle as compiled by the relevant Provincial or Divisional office.

	Period		Injury/disease/incapacity (Description/diagnoses)	Medical certificate	
Start date	End date	No of working days	(Description/diagnoses)	Yes	No
					-
	(4)				-
	-				

				-					
				-					-
				-					
				-					
C.	IMPACT RECOMI	OF INCAPA	CITY ON EM	PLOYEE'S	PERFORMA	NCE (NO	MEDICAL	COMMEN	TS OR
1.	Describe	e the impact of th nmental factors	e injury/disease o	on the emplo	oyee's work ab	ilities, with re	ference to sp	pecific work	duties an
2.	Describe	any other factors	s, either at work o	r outside w	ark which coul	d he contribut	fog to the		
	perform	his/her duties sa	tisfactorily	outside wi	ork, writeri coul	o be contribut	ung to the en	nployee's dif	ficulties to
	13-21								
	Describe t	the efforts made	to accommodate	the enclose	and the state of				
	and dutie	es chorts made	to accommodate	the employ	ee's impairmei	nt/incapacity t	by adapting t	the work env	ironment
	Was the em	ployee referred to	the EHW?						16732
		-							V
243									
	List alternati	ve jobs in the Se	rvice, together wit	th a brief de	scription, which	the employe	e may be abl	e to perform	
		3/5							

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Compulsory Documents to be attached

Att	tachments	Tick ·
	SAPS 47 (previous & current sick leave cycle)	i
	Medical certificate(s)	
	Current Medical reports from specialists (Not older than 6 months, if applicable)	
	EHW report (psychological and terminally ill cases)	
	Commander's report	
	Minutes of career discussion	
	Supportive collateral information	
	Copy of identification document of the employee	
	Certified copy of PERSAL 4.5.11, indicating that this temporary incapacity leave has been captured	
	All relevant medical reports (example: X-ray reports)	-
	Additional written motivation	
	Copy of employee's job description	7
jury	/Illness on duty/arisen out of the performance of official duties	
	SO 125 / Convening order in terms of Regulations 5(1) & 68(1)(a)	
	SAPS 114	
	WCL 2 (Employer' Report)	
	WCL 4 (First Medical Report)	
	WCL 303 & WCL 304 in cases of PTSD	
	Statement by employee	
	Statement by commander/supervisor (on/off duty during incident)	
2.9	Statement by person to whom injury/illness was reported first	
	Statement(s) by eye witness(es)	

E. Declaration by commander/supervisor

I hereby declare that the information given is factual, true and correct, and that no material information has been withheld nor any relevant circumstances omitted.

Initial & Surname	Sig	nature	Rank	
			Name	Dat
ort 3 Statement by treating docto		compulsory)		
Particulars of the employee	Patient)			
First names				
PERSAL number				
Rank		Date of birth		
Date of first consultation		Occupation		
Date of first consultation		Date of last consu	ultation	
. Main diagnosis and cause				
. Main diagnosis and cause	of the injury/disea	ise/ill-health		
Detail the onset and history	of the injury/disea	ise/ill-health	nt	Response
Detail the onset and history Give details of your consulta	of the injury/disea	ent over the last year	nt	Response
Detail the onset and history Give details of your consulta	of the injury/disea	ent over the last year	nt	Response
Detail the onset and history Give details of your consulta	of the injury/disea	ent over the last year	nt .	Response
Detail the onset and history Give details of your consulta	of the injury/disea	ent over the last year	nt .	Response

5.	Detail objective findings, such as blood tests, results (Attach copies of available reports)	X-ray reports, ECG's, ec	hocardiographs and	histol
6. D	escribe the nature and extent of the function	al impairment/s		
. Do				
yes, descr	pes the patient's work, duties and/or environs ibe	nent aggravate the injury	y or disease?	es No
Ple	ase provide details of other medical practition	oners consulted or of he	venital admissions during	
Date	Medical practitioner/hospital			
	medicai practitioner/nospitai	Speciality	Treatment/surg	ery
Pleas etc.	se provide details of present treatment, incl	uding medication and d	osages, rehabilitation, co	unselling,
				× 1
Provid				
	de details of any complications or side effect	s of treatment		
	de details of any complications or side effect	s of treatment		1:10

	214
11.	Please comment on the patient's response and compliance to current treatment
12.	What further treatment, procedure or investigation would you recommend?
13.	What further rehabilitation is envisaged for the patient?
14.	Please comment on the patient's further employment/redeployment within the South African Police Service, taking into account that the Service has a large variety of occupations over and above active policing.
5. (Comment on the patient's employability within the open labour market
ı c	omment on the employee's engagement in a private occupation or business, if involved in any.
Pro	ognosis
nature of	medical practitioner
t name (in	block letters)
ifications	(specify)
tice numl	Der .

Date	Tel no
Physical address	

ANNEXURE R

SAPS 552C

SOUTH AFRICAN POLICE SERVICE 216



APPLICATION FOR LONG TERM INCAPACITY LEAVE / ILL-HEALTH RETIREMENT

IMPORTANT

- This application form must be completed in respect of temporary incapacity leave for a period of 30 working days or more and if application is made for ill-health retirement.
- Please note that an employee must proof to the satisfaction of the Service that he or she is incapable of performing work as a result of an illness or injury.
- In keeping with the principles contained in item 10 of Schedule 8 of the Labour Relations Act, 1995, this application affords the employee the opportunity to submit medical evidence relating to his or her medical condition (such as medical reports from a specialist, blood tests results, x-ray results, results from scans, etc.) or any other motivation which he or she deems relevant and in support of his or her application and which the employee believes that the employer should take into account when considering his or her application for temporary incapacity leave or for ill-health retirement.
- Please ensure that this form is fully completed, signed and accompanied by all the necessary documentation. An incomplete form or the absence of the necessary supporting documentation will delay the finalization of the application.
- An investigation in terms of National Instruction 2/2004 may be conducted in respect of this application.
- Please note that if the application for incapacity leave is declined, the period of absence will be converted to either annual leave, capped leave or unpaid leave.
- This application form and supporting documentation is classified as "Confidential".

AUTHORIZATION

		וט א
PERSAL No	loyee of the South African Police is prize/refuse to authorize institution, Polmed or any other med son that may hold any medical recornish and release to the Employer any information, relating to any illness, a laboratory results (including blood is and treatments, progress reports oner and any other person who has in I have received any medical treatments.)	Service (hereinafter (delete whichever is not ical scheme, clinical scheme, clinical scheme, clinical scheme, clinical scheme, clinical scheme, clinical scheme, conditional details and injury or conditionand other tests), x is and summaries provided treatment ment of any nature (e) the Employer to
disclose and make available to the Health Risl well as any other information that may be in applications for temporary incapacity leave, m related records.	the possession of the Employer,	including previous
I further authorize/refuse to authorize/refuse to authorize/refuse to authorize/refuse to authority shall confirm that a photocopy of this authority shall	of the aforementioned information in	its possession to
Signed at on this		
Employee or other person completing the for		
Signature of witness 1	Date	
Full Name & Surname:		
Tel No.:	Code	
Cell No.:		
Signature of witness 2	Date	
Full Name & Surname:		
Tel No.:	Code	
Cell No.:		

CONSENT TO UNDERGO MEDICAL EXAMINATION

I acknowledge that for the employer to consider and evaluate any application for incapacity or ill health benefits, I may be required to undergo a medical or psychological evaluation and other tests including, without limiting the generality of the afore-going, 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 after 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 attached to my non-keeping of the appointment from me.

I undertake to present myself for any appointment timely 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 on my failure to attend will be payable in full by me on demand by the employer.

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I hereby indemnify the Employer and its Health Risk Manager against any claim of whatever nature, which may be made against them as a result of, or arising from the furnishing of any information as provided for herein.

Signature of witness 1	Date	
Full Name & Surname:		
Tel No.:	Code	
Cell No.:		
Signature of witness 2	Date	
Full Name & Surname:		
Tel No.:	Code	
Cell No.:		