MEDICAL QUESTIONNAIRE

Annexure H

Employee: Complete Section 1-6
Health/Medical Practitioner: Complete Section 7-9
Please use block capital to complete this questionnaire

Employee No: _____

SECTION 1: PERSONAL DETAILS

Title | Initials | Surname

First Names

ID Number

Date of birth (y y y y m m d d)

Marital Status: Single | Married | Divorced | Widow/Widower

Position

Rank

Act: mark | Police Professional | Public Service Act

Division

Phone No: | OR

Email Address

SECTION 2: PREVIOUS WORK HISTORY

Have you been employed by any company other than your current employer where you might have been exposed to various hazards within the work place?

Yes | No

If "yes", state full details:

Name of the Employer	Start (year)	End (year)	Type of exposure (e.g. Noise, Chemicals, Asbestos)
1			
2			
3			

SECTION 3: HABITS

3.1	Have you ever smoked in the past 12 months?		Yes		No		
3.2	If yes, indicate your daily consumption:	Cigarette:		Cigars:		Pipe:	
3.3	What type and amount of alcoholic liquor do you consume?			Type :			
	Amount per day:	Amount per week:					

SECTION 4: FAMILY HISTORY

Have any of your close blood relative ever suffered from heart attacks, angina, high blood pressure, stroke, diabetes, sugar in the urine, asthma, heart failure, cancer, raised cholesterol, mental illness or any other hereditary disease?

Yes: | No:

If "yes", state full details:

Relationship	Age:			Condition
	Current	At diagnosis	At death	
Father				
Mother				
Brother				
Sister				

SECTION 5: PERSONAL MEDICAL HISTORY

Have you ever suffered from any of the following conditions?				Details
5.1	Disorders of the heart, e.g. rheumatic fever, heart murmurs, palpitations chest pain or discomfort (including angina), shortness of breath, cardiac failure or heart attack	Yes	No	
5.2	High blood pressure, raised cholesterol, (diseases of the blood vessels) or circulatory disorder	Yes	No	
5.3	Lung disorder, e.g. TB, Asthma, Chronic bronchitis, persistent cough or wheezing or any other respiratory disorder?	Yes	No	
5.4	Disorders of the digestive system, stomach, gall bladder, pancreas or liver, e.g. recurrent indigestion or heartburn, stomach/duodenal ulcers, hiatus hernia, jaundice, rectal bleeding, piles, or have ever had gastroscopy, colonoscopy or any special investigation?	Yes	No	
5.5	Diseases or disorders of the kidney, bladder or reproductive organs, e.g. abnormal urine test, kidney stones, kidney or bladder infections, salpingitis or prostatitis?	Yes	No	
5.6	Any major dental, chiropractic, optical or gynaecological treatment, advice, special investigations, or been hospitalised for these or any similar conditions?	Yes	No	
5.7	Received advice or treatment in connection with HIV/AIDS or any other sexually transmitted diseases, e.g. hepatitis B, gonorrhea, or syphilis?	Yes	No	
5.8	Disorders of the nervous system, e.g. epilepsy or fits, blackouts or stroke	Yes	No	
5.9	Mental disorders, e.g. anxiety, depression, panic attacks, post traumatic stress disorder?	Yes	No	
5.10	Any medical advice, counselling or treatment for alcohol or drug dependency?	Yes	No	
5.11	Ear, eye, nose or throat disorders, e.g. poor vision, glaucoma, cataracts, hearing loss, ear discharge, hoarseness, post nasal drip or allergies?	Yes	No	
5.12	Diseases or disorders of the skin, muscles, joints, limbs, spine. E.g. skin rash, eczema, rheumatism, arthritis, gout, any other back trouble or physical disability?	Yes	No	
5.13	Diabetes, high blood glucose during pregnancy, thyroid or other hormonal or blood disorder, e.g. anaemia, leukemia, Hodgkin's disease, iron deficiency or bleeding tendency?	Yes	No	
5.14	Cancer, growth or tumour of any kind including moles removed?	Yes	No	
5.15	Any work related disease or injury that was reported to the Compensation Commissioner?	Yes	No	
5.17	If not already mentioned above have you had any other illness or disorder not mentioned above including chronic fatigue syndrome (Yippie flu), fibromyalgia, tropical disease such as bilharzias or malaria?	Yes	No	
5.18	Females: Are you currently pregnant? If so, when is the expected date of delivery? Date:_____	Yes	No	
5.19	Females: Have you ever given birth to a baby weighing more than 4.1kg?	Yes	No	

If not already stated, have you had any of the following in the past 5 years:
If yes, please provide details.

1	Any X-ray, ECG or any other investigations or special examinations or had any operation?	Yes	No	
2	Taken any medication including anti-depressants, tranquilizers or drugs including cannabis (dagga), cocaine, ecstasy, anabolic steroids, etc for medical or other reasons?	Yes	No	
3	Consulted any doctor or other practitioner, e.g. chiropractor, homeopaths, reflexologists or traditional healers?	Yes	No	
4	Any routine check-ups or medical examination for insurance purpose?	Yes	No	
5	Been hospitalised for any medical condition, psychiatric problem or injuries (maternity confinement excluded)?	Yes	No	

Names and addresses of usual medical attendants consulted by you over the past 5 years:

Doctor's Name	Address

SECTION 6: DECLARATION BY EMPLOYEE

I declare and warrant that this Personal Statement, whether by my own handwriting or not, is completed in true and understand that any misstatement or non-disclosure may render invalid any contract of service that may be offered.

Name _____ Signature _____ Date _____

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ANNEXURE I

South African Police Services: Operational Response Services: External Deployments

Date

PRE DEPLOYMENT
CERTIFICATE OF MEDICAL FITNESS

***

FAMILY NAME | FIRST NAME (S)

FORCE NO. | SA ID No.

Job Title / Rank

The examination consisted of : Personal, relevant occupational & family medical histories, Physical examination with Urinalysis and Special examinations, if required, consisting of a selection of the following options :

1. Spirometry / Peak flow 2. Audiometry 3. Operators / drivers vision test 4. Snellen test
5. Additional tests as indicated / required for the post or by the employer

PRE DEPLOYMENT FITNESS STATUS

Commensurate with the level of examination requested by the employer *and or* the medical fitness requirements for the job description / post / job category the candidate / incumbent has been found to be :

Pre-deployment : Fit to work and reside without restrictions or limitations in :

Comments :

Blood Group/Type: Allergies:

The results of this medical are subject to medical confidentiality and ethical rules.

Name & title of examiner : _____

Signature of examiner : _____

STAMP

ANNEXURE J

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FAO	IAEA	ILO	ITC	ITU	UN	UNDP	UNESCO	UNICEF	UNIDO	WHO	WIPO	WMO	WTO

CONFIDENTIAL

ENTRY MEDICAL EXAMINATION

UNITED NATIONS AND SPECIALIZED AGENCIES

I hereby authorize any of the doctors, hospitals or clinics mentioned in this form to provide the United Nations Medical Service with copies of all my medical records so that the Organization can take action upon my application for employment.

I certify that the statements made by me in answer to the questions below are, to the best of my knowledge, true, complete and correct. I realize that any incorrect statement or material omission in the medical information form or in any other document required by the Organization renders a staff member liable to termination or dismissal.

Date:(dd/mm/yy) ..... Signature: .....

Pages 1 and 2 are to be completed by the candidate

FAMILY NAME (IN BLOCK CAPITALS)	GIVEN NAMES	MAIDEN NAME (FOR WOMEN ONLY)	SEX ☐ M ☐ F

ADDRESS (STREET, TOWN, DISTRICT OR PROVINCE, COUNTRY)

DATE OF BIRTH

NATIONALITY

POSITION APPLIED FOR (DESCRIBE NATURE OF WORK)

TELEPHONE

BIRTHPLACE

DUTY STATION

PRESENT MARITAL STATUS

Single ☐

Married ☐ DATE: (d/m/y) .....

Divorced ☐ DATE: (d/m/y) .....

Separated ☐ DATE: (d/m/y) .....

Widowed ☐ DATE: (d/m/y) .....

Have you ever undergone a medical examination for the United Nations or one of its agencies?

Have you ever been employed by the United Nations or one of its agencies?

If so, please state when, where and for which Organization:

.....

.....

.....

FAMILY HISTORY

Relative	Age (if still alive)	State of Health (If still alive, present state; if deceased, cause of death)	Age At death	Have members of your family had the following illnesses or disorders?	Yes	No	Who?
Father				High Blood Pressure	☐	☐	
Mother				Heart Disease	☐	☐	
Brothers				Diabetes	☐	☐	
Sisters				Tuberculosis	☐	☐	
Spouse				Asthma	☐	☐	
Children				Cancer	☐	☐	
				Epilepsy	☐	☐	
				Mental Disorders	☐	☐	
				Paralysis	☐	☐	

TO BE COMPLETED BY THE OFFICIAL REQUESTING THE MEDICAL EXAMINATION	TO BE COMPLETED BY THE DIRECTOR OF THE MEDICAL SERVICE
Name of Official:	Medical Classification: 1a 1b 2a 2b
Department or Unit:	Comments: .....
Date:	DATE: (d/m/y) Signature:

VERY IMPORTANT: ***Please indicate the recruiting Agency or Organization:***

ANNEXURE K

ANNEXURE K:

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PART1:
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:

1. 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.

2. You understand the process at which these assessments are being administered following proper explanation.

3. You have had an opportunity to ask clarity seeking questions relating to the administration of the health and wellness screening/ assessments mentioned above.

4. You understand that the abovementioned health and wellness screening/ assessments are entirely voluntary.

5. 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.

6. 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.

7. 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.

8. 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 _____

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PART2:

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

HIV management/ support: Registration on the Disease Risk Management (DRM) Programme	YES		NO	
TB management/ support Registration on the Chronic Risk Management (CRM) Programme	YES		NO	
Psycho-social support	YES		NO	

Other, please specify: _____

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

1. I hereby confirm that the information provided in this consent form is true and correct.
2. 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.
3. 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.
4. 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

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)

PROVINCE	TOTAL ESTABLISHMENT AS AT 30 JUNE 2023 [BASELINE ESTIMATE]	HCT TARGETS TO BE TESTED BY 31 MARCH 2025 (20% OF THE TOTAL ESTABLISHMENT)	QUARTERLY HCT TARGET [01 APRIL 2024 – 31 MARCH 2025]
HEAD OFFICE DIVISIONS	26 593	5 319	1 330
WESTERN CAPE	22 647	4 529	1 132
EASTERN CAPE	22 094	4 419	1 105
NORTHERN CAPE	8 120	1 624	406
FREE STATE	13 767	2 753	6 88
KWA-ZULU NATAL	27 291	5 458	1 365
NORTH WEST	11 147	2 229	557
MPUMALANGA	11 223	2 245	561
LIMPOPO	13 616	2 723	681
GAUTENG	36 798	7 360	1 840
TOTAL	**193 296**	**38 659**	**9 665**

ANNEXURE M

ANNEXURE N

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

GENERAL HEALTH RISK ASSESSMENTS (HRA)

PROVINCE	TOTAL ESTABLISHMENT AS AT 30 JUNE 2023 [BASELINE ESTIMATES]	HRA TARGETS TO BE TESTED BY 31 MARCH 2025 (30% OF THE TOTAL ESTABLISHMENT)	QUARTERLY HCT TARGET [01 APRIL 2024 – 31 MARCH 2025]
HEAD OFFICE DIVISIONS	26 593	7 978	1 995
WESTERN CAPE	22 647	6 794	1 699
EASTERN CAPE	22 094	6 628	1 657
NORTHERN CAPE	8 120	2 436	609
FREE STATE	13 767	4 130	1 033
KWA-ZULU NATAL	27 291	8 189	2 047
NORTH WEST	11 147	3 344	836
MPUMALANGA	11 223	3 367	842
LIMPOPO	13 616	4 085	1 021
GAUTENG	36 798	11 039	2 760
TOTAL	**193 296**	**57 989**	**14 497**

ANNEXURE O

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SOUTH AFRICAN POLICE SERVICE

APPLICATION FORM:

TEMPORARY INCAPACITY LEAVE SHORT PERIODS

(Period from 1 to 14 working days)

IMPORTANT

1. This application form must be completed in respect of a period of temporary incapacity leave of less than 15 working days.

2. 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.

4. 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.

5. An investigation in terms of National Instruction 2/2004 may be conducted in respect of this application.

6. Please note that if this application is declined, the period of absence will be converted to either annual leave, capped leave or unpaid leave.

7. This application form and supporting documentation is classified as "Confidential".

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AUTHORIZATION

I ..... ID No .....

PERSAL No ..... an employee of the South African Police Service (hereinafter referred to as "the Employer") hereby **authorize/refuse to authorize** (delete whichever is not applicable) any medical practitioner, hospital, institution, clinic, health care provider or any other relevant person that may hold any medical records relating to me or any treatment or advice provided to me, to furnish and release to the Employer 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 medications 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.

I hereby **authorize/refuse to authorize** (delete whichever is not applicable) 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 possession of the Employer, including previous applications for temporary incapacity leave, medical reports, job descriptions and specifications and related records.

I further **authorize/refuse to authorize** (delete whichever is not applicable) the Health Risk Manager to disclose and make available any of the aforementioned information in its possession to the Employer.

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

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:			
Tel No.:		Code	
Cell No.:			

CONFIDENTIAL

SAPS 552 (A)

SOUTH AFRICAN POLICE SERVICE

SUID-AFRIKAANSE POLISIEDIENS

For office use only

Reference number	SAPS	Prov/Div	HO	Type of application
				Short term

First date of absence, eg 2006/05/17	PERSAL number	Authorization number(s)

PART 1 To be completed by the employee

A. Personal particulars

PERSAL number				Rank				
Component/Section/Station/Unit								
Job title								
Surname								
First names								
Identity number								
Date of birth				Age				
Date of appointment				Already on sick leave	Yes		No	
Salary level				Date of last day at work				
Pension fund				Date duty resumed				
Shift worker	Yes		No	Gender	M		F	
Is the injury or illness the result of an injury on duty (IOD)?	Yes		No	If Yes - Regulation 8(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	

C. Nature of injury/disease/incapacity (brief description)

D Application for temporary incapacity leave

Period		Injury/disease/incapacity (Description/diagnosis)	Medical certificate
Start date	End date		Yes / No

E Details of occupation

1. Describe your current duties and functions

2. Describe the physical demands of the job

3 Describe the mental demands of the job

4 Describe the tools, equipment and materials used to perform the job

5.	Indicate your highest level of education

6.	Are you performing other remunerative work? If yes, describe as you have in E1 up to E4 on a separate folio.

F. Details of incapacity

1.	Describe the injury / disease that has given rise to this application (only one)

2.	Details of medical consultation in relation to this application		
Name of doctor		Date of first consultation	
Specialist		Tel no	
Address			
Date of last consultation			

G. Details of doctors, specialists, other health professionals and hospitals you have consulted pertaining to your incapacity

1. Period		Doctor/hospital/other	Speciality	Address & tel. no	Treatment received
From	To				

2.	Details of other concurrent or past injuries/diseases/illnesses which in your opinion may have contributed to your incapacity

H. Details of the impact of your health condition on your work performance and other functions and the practical implications of your injury / disease on the following activities of daily 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, sitting, bending, carrying, etc.)

3 Self-care (eating, dressing, bathing, etc.)

4 Management of home (domestic chores, gardening, shopping, home maintenance, etc.)

5 Transport (driving, use of public transport, etc.)

6 Sport and recreational activities

I. 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.

Signature of employee	Print name	Rank	Date

Signature of person completing this form if the employee is incapacitated	Print name	Rank	Date

Signature of witness if applicant is incapacitated	Print name	Rank	Date

PART 2 Statement by employer

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

Initials & Surname			
Post title			
Rank			
Physical address	Station		
	Component		
	Province/Division		
Postal address			
		Postal code	
Tel number		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		Yes	No

C. IMPACT OF INCAPACITY ON EMPLOYEE'S PERFORMANCE (NO MEDICAL COMMENTS OR RECOMMENDATIONS)

1. Describe the impact of the injury/disease on the employee's work abilities, with reference to specific work duties and environmental factors

2. Describe any other factors, either at work or outside work, which could be contributing to the employee's difficulties to perform his/her duties satisfactorily

3. Describe the efforts made to accommodate the employee's impairment/incapacity by adapting the work environment and duties

4. Was the employee referred to the EAS?

5. List alternative jobs in the Service, together with a brief description, which the employee may be able to perform

D. Compulsory Documents to be Attached

Attachments	Tick ✓
• SAPS 47 (previous & current sick leave cycle)	
• Medical certificate(s) COMPULSORY WITH SPECIFIED DIAGNOSES	
• Current Medical reports from specialists (Not older than 6 months, if applicable)	
• EAS report (ONLY FOR PSYCHOLOGICAL & TERMINALLY ILL CASES)	
• Commander's report (OPTIONAL)	
• Certified copy of Per 4.5.11, indicating that this temporary incapacity leave has been captured	
• All relevant medical reports (example: X-ray reports) (OPTIONAL)	
• Additional written motivation (OPTIONAL)	
Injury/Illness on duty/Arose 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)	
• 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.

I, _____ the commander/supervisor hereby also certifies that the leave records of the employee concerned was verified by me on _____ and that all absence has been captured on Persal, including the periods of temporary incapacity leave applied for in this application. Persal 4.5.11 was verified by me and the SAPS 47 and Persal 4.5.11 do correspond.

Initial & Surname	Signature	Rank	Date

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

Initial & Surname of perusing officer	Signature of perusing officer	Date

ANNEXURE P

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CONFIDENTIAL

SAPS 552 (B)

SOUTH AFRICAN POLICE SERVICE

APPLICATION FORM:

TEMPORARY INCAPACITY LEAVE
SHORT PERIODS

(Period from 15 to 29 working days)

IMPORTANT

1. 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.

2. 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.

4. 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.

5. An investigation in terms of National Instruction 2/2004 may be conducted in respect of this application.

6. Please note that if this application is declined, the period of absence will be converted to either annual leave, capped leave or unpaid leave.

7. This application form and supporting documentation is classified as "Confidential".

AUTHORIZATION

I ..... ID No .....

PERSAL No ..... an employee of the South African Police Service (hereinafter referred to as "the Employer") hereby **authorize/refuse to authorize** (delete whichever is not applicable) any medical practitioner, hospital, institution, clinic, health care provider or any other relevant person that may hold any medical records relating to me or any treatment or advice provided to me, to furnish and release to the Employer 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 medications 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.

I hereby **authorize/refuse to authorize** (delete whichever is not applicable) 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 possession of the Employer, including previous applications for temporary incapacity leave, medical reports, job descriptions and specifications and related records.

I further **authorize/refuse to authorize** (delete whichever is not applicable) the Health Risk Manager to disclose and make available any of the aforementioned information in its possession to the Employer.

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

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:			
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.

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 for herein.

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:			
Tel No.:		Code	
Cell No.:			

CONFIDENTIAL

SAPS 562 (B)

SOUTH AFRICAN POLICE SERVICE

SUID-AFRIKAANSE POLISIEDIENS

For office use only

Reference number	SAPS	Prov/Div	HO	Type of application
				Short term

First date of absence, eg 2006/05/17	PERSAL number	Authorization number(s)

PART 1 To be completed by the employee

A. Personal particulars

PERSAL number				Rank				
Component/Section/Station/Unit								
Job title								
Surname								
First names								
Identity number								
Date of birth				Age				
Date of appointment				Already on sick leave	Yes		No	
Salary level				Date of last day at work				
Pension fund				Date duty resumed				
Shift worker	Yes		No	Gender	M		F	
Is the injury or illness 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	

C. Application for temporary incapacity leave

Period		Injury/disease/incapacity (Description/diagnosis)	Medical certificate
Start date	End date		Yes / No

D. Details of occupation

1 Describe your current duties and functions

2 Describe the physical demands of the job

3 Describe the mental demands of the job

4. Describe the tools, equipment and materials used to perform the job

5 Indicate your highest level of education

6. Are you performing other remunerative work? If yes, describe as you have in E1 up to E4 on a separate folio

E. Details of incapacity

1 Describe the injury / disease that has given rise to this application (only one)

2 Details of medical consultation in relation to this application			
Name of doctor		Date of first consultation	
Specialist		Tel no	
Address			
Date of last consultation			

F. Details of doctors, specialists, other health professionals and hospitals you have consulted pertaining to your incapacity

1. Period		Doctor/hospital/other	Speciality	Address & tel no	Treatment received
From	To				

2 Details of other concurrent or past injuries/diseases/illnesses which in your opinion may have contributed to your incapacity

G. Details of the impact of your health condition on your work performance and other functions and the practical implications of your injury / disease on the following activities of daily 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, sitting, bending, carrying, etc.)

3	Self-care (eating, dressing, bathing, etc.)

4	Management at home (domestic chores, gardening, shopping, home maintenance, etc.)

5	Transport (driving, use of public transport, etc.)

6	Sport and recreational activities

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

Signature of employee	Print name	Rank	Date

Signature of person completing this form if the employee is incapacitated	Print name	Rank	Date

Signature of witness if applicant is incapacitated	Print name	Rank	Date

PART 2 Statement by employer

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

Initials & Surname			
Post title			
Rank			
Physical address	Station		
	Component		
	Province/Division		
Postal address			
		Postal code	
Tel. number		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		Yes	No

C. IMPACT OF INCAPACITY ON EMPLOYEE'S PERFORMANCE (NO MEDICAL COMMENTS OR RECOMMENDATIONS)

1.	Describe the impact of the injury/disease on the employee's work abilities, with reference to specific work duties and environmental factors

2	Describe any other factors, either at work or outside work, which could be contributing to the employee's difficulties to perform his/her duties satisfactorily

3	Describe the efforts made to accommodate the employee's impairment/incapacity by adapting the work environment and duties

4	Was the employee referred to the EAS?

5	List alternative jobs in the Service, together with a brief description, which the employee may be able to perform

D. Compulsory Documents to be Attached

Attachments	Tick ✓
• SAPS 47 (previous & current sick leave cycle)	
• Medical certificate(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)	
• Commander's report (OPTIONAL)	
• Minutes of career discussion	
• Supportive collateral information (OPTIONAL)	
• 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) (OPTIONAL)	
• Additional written motivation (OPTIONAL)	
Injury/illness on duty/arisen out of the performance of official duties	
• SO 125 / Convening order in terms of Regulations 5(1) & 66(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)	
• 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.

I, _____ the commander/supervisor hereby also certifies that the leave records of the employee concerned was verified by me on _____ and that all absence has been captured on Persal, including the periods of temporary incapacity leave applied for in this application. Persal 4 5 11 was verified by me and the SAPS 47 and Persal 4.5.11 do correspond.

Initial & Surname	Signature	Rank	Date

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

Initial & Surname of perusing officer	Signature of perusing officer	Date

ANNEXURE Q

SAPS 552C

SOUTH AFRICAN POLICE SERVICE 201

APPLICATION FORM:

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

OR

ILL-HEALTH RETIREMENT

202

IMPORTANT

1. This application form must be completed in all instances where the medical evaluation has been initiated by the Employer.

2. 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 Ill-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 ill-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".

I hereby certify that I have read the above and understand the contents thereof.

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:			
Tel No.:		**Code**	

203

AUTHORIZATION

I ..... ID No .....

PERSAL No ..... an employee of the South African Police Service (hereinafter referred to as "the Employer") hereby **authorize/refuse to authorize** (delete whichever is not applicable) any medical practitioner, hospital, institution, Polmed or any other medical scheme, clinic, health care provider or any other relevant person that may hold any medical records relating to me or any treatment or advice provided to me, to furnish and release to the Employer 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 medications 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.

I hereby **authorize/refuse to authorize** (delete whichever is not applicable) 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 possession of the Employer, including previous applications for temporary incapacity leave, medical reports, job descriptions and specifications and related records.

I further **authorize/refuse to authorize** (delete whichever is not applicable) the Health Risk Manager to disclose and make available any of the aforementioned information in its possession to the Employer.

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

Signed at ..... on this ..... 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:			
Tel No.:		**Code**	
Cell No.:			

204

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.

Signed at ..... on this ..... 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:			
Tel No.:		**Code**	
Cell No.:			

205

SOUTH AFRICAN POLICE SERVICE

SUID-AFRIKAANSE POLISIEDIENS

For office use only

Reference number	SAPS	Prov/Div	HO	Type of application
				(Full Functional Assessment)

First date of absence, eg 2006/05/17	PERSAL number	Authorization number(s)

PART 1 To be completed by the employee

A. **Personal particulars**

PERSAL number			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			Employment Category Act	Police Act		Public Service Act	
Salary level			Date of last day at work				
Higher/Academic Qualifications							
Pension fund			Date duty resumed				
Shift worker	Yes		No	Gender	M		F	
Is the injury or illness 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**	

C. Nature of application

Reason for application	Brief description of injury/disease/incapacity
Full functional medical Assessment initiated by Employer	

D. Details of occupation

1. Describe your current duties and functions

2. Describe the physical demands of the job

3. Describe the mental demands of the job

4. Describe the tools, equipment and materials used to perform the job

5. Indicate your highest level of education

6. Are you performing other remunerative work? If yes, describe as you have in E1 up to E4 on a separate folio.

E. Details of incapacity

1. Describe the injury / disease that has given rise to this application (only one)

2. Details of medical consultation in relation to this application			
Name of doctor		Date of first consultation	
Specialist		Tel no	
Address			
Date of last consultation			

F. Details of doctors, specialists, other health professionals and hospitals you have consulted pertaining to your incapacity

1. Period		Doctor/hospital/other	Speciality	Address & tel. no	Treatment received
From	To				

2. Details of other concurrent or past injuries/diseases/illnesses which in your opinion may have contributed to your incapacity

G. Details of the impact of your health condition on your work performance and other functions and the practical implications of your injury / disease on the following activities of daily 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, sitting, bending, carrying, etc.)

3. Self-care (eating, dressing, bathing, etc.)

4.	Management at home (domestic chores, gardening, shopping, home maintenance, etc.)

5.	Transport (driving, use of public transport, etc.)

6.	Sport and recreational activities

I. 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.

Signature of employee	Print name	Rank	Date

Signature of person completing this form if the employee is incapacitated	Print name	Rank	Date

Signature of witness if applicant is incapacitated	Print name	Rank	Date

PART 2 Statement by employer

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

Initials & Surname			
Post title			
Rank			
Physical address	Station		
	Component		
	Province/Division		
Postal address			
		Postal code	
Tel. number		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		Yes	No

C. IMPACT OF INCAPACITY ON EMPLOYEE'S PERFORMANCE (NO MEDICAL COMMENTS OR RECOMMENDATIONS)

1. Describe the impact of the injury/disease on the employee's work abilities, with reference to specific work duties and environmental factors

2. Describe any other factors, either at work or outside work, which could be contributing to the employee's difficulties to perform his/her duties satisfactorily

3. Describe the efforts made to accommodate the employee's impairment/incapacity by adapting the work environment and duties

4. Was the employee referred to the EHW?

5. List alternative jobs in the Service, together with a brief description, which the employee may be able to perform

Z11

D. Compulsory Documents to be attached

Attachments	Tick √
• SAPS 47 (previous & current sick leave cycle)	
• 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	
Injury/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)	
• Statement by person to whom injury/illness was reported first	
• Statement(s) by eye witness(es)	
• Copy of Occurrence Book (OB) entry	

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.

I, _____ the commander/supervisor hereby also certify that the leave records of the employee concerned was verified by me on _____ and that all absence has been captured on Persal, including the periods of temporary incapacity leave applied for in this application. Persal 4.5.11 was verified by me and the SAPS 47 and Persal 4.5.11 do correspond.

Initial & Surname	Signature	Rank	Date

Part 3 Statement by treating doctor (specialist report compulsory)

A. Particulars of the employee (Patient)

Surname			
First names			
PERSAL number		Date of birth	
Rank		Occupation	
Date of first consultation		Date of last consultation	

B. Medical details

1. Main diagnosis and cause of disablement/incapacity

2. Detail the onset and history of the injury/disease/ill-health

3. Give details of your consultations with the patient over the last year			
Date	Diagnosis	Treatment	Response

4. Details of the last clinical evaluation

5. Detail objective findings, such as blood tests, X-ray reports, ECG's, echocardiographs and histology results (Attach copies of available reports)

6. Describe the nature and extent of the functional impairment/s

7. Does the patient's work, duties and/or environment aggravate the injury or disease?	Yes	No
If yes, describe		

8. Please provide details of other medical practitioners consulted or of hospital admissions during the past 5 years

Date	Medical practitioner/hospital	Speciality	Treatment/surgery

9. Please provide details of present treatment, including medication and dosages, rehabilitation, counselling, etc.

10. Provide details of any complications or side effects of treatment

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.

15. Comment on the patient's employability within the open labour market

16. Comment on the employee's engagement in a private occupation or business, if involved in any.

17. Prognosis

Signature of medical practitioner	
Print name (in block letters)	
Qualifications (specify)	
Practice number	

215

Date		Tel no	
Physical address			

ANNEXURE R

SAPS 552C

SOUTH AFRICAN POLICE SERVICE Z16

APPLICATION FOR LONG TERM INCAPACITY LEAVE / ILL-HEALTH RETIREMENT

217

IMPORTANT

1. 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.**

2. 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 or for ill-health retirement.

4. 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.

5. An investigation in terms of National Instruction 2/2004 may be conducted in respect of this application.

6. 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.

7. This application form and supporting documentation is classified as "Confidential".

Z 18

AUTHORIZATION

I ..... ID No .....

PERSAL No ..... an employee of the South African Police Service (hereinafter referred to as "the Employer") hereby **authorize/refuse to authorize** (delete whichever is not applicable) any medical practitioner, hospital, institution, Polmed or any other medical scheme, clinic, health care provider or any other relevant person that may hold any medical records relating to me or any treatment or advice provided to me, to furnish and release to the Employer 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 medications 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.

I hereby **authorize/refuse to authorize** (delete whichever is not applicable) 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 possession of the Employer, including previous applications for temporary incapacity leave, medical reports, job descriptions and specifications and related records.

I further **authorize/refuse to authorize** (delete whichever is not applicable) the Health Risk Manager to disclose and make available any of the aforementioned information in its possession to the Employer.

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

Signed at ..... on this ..... 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:			
Tel No.:		**Code**	
Cell No.:			

219

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 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.

Signed at ..... on this ..... 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:			
Tel No.:		**Code**	
Cell No.:			