



**FIRST MEDICAL REPORT IN RESPECT OF
AN ACCIDENT**
COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993
(Act No. 130 of 1993)

[Section 6A(b) – Commissioner’s Rules, Forms and Particulars – Annexure 15]

Names and Surname of Employee

Identity Number Address Postal Code

Name of Employer

Address Postal Code

Date of accident

1. Date of your first consultation

2. How did the alleged accident happen?

3. Full clinical description of injury (ies) (**not symptoms, signs or syndromes**)

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4. Describe briefly any **pre-existing** defect or disease

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5. X-Rays Date By whom

(Attach report if available)

6. Surgical Procedures: Date By whom

Brief description

7. Anaesthetics: General / Local Duration

8. (a) Consultation Yes / No With whom Date

(b) Was the employee referred for physiotherapy? Yes / No Physiotherapist

9. (a) Is the employee unfit for work? Yes / No

(b) Possible date fit for: Light duty Normal duty

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

Signature of Medical Practitioner/Chiropractor

Name (Printed) Date (important)

Address

Postal Code Practice number

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