THE FEDERATED EMPLOYERS' MUTUAL ASSURANCE COMPANY (RF) (PTY) LTD

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COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 AS AMENDED
ELBOW

EMPLOYEE DETAILS

Claim Number:	**Date of Accident:**	**Staff Number:**
Name of Employer:		
Name of Employee:		

1.	Injured side			Left:		Right:		Both
2.	Evidence of scaring:							
3.	Was surgery performed:			Yes			No	
4.	Amputation:			Yes			No	
	If yes, please indicate the level:							
5.	Is the elbow deformed:			Yes			No	
	If yes, please provide a description of the deformation							
	Radius and ulna deformed			Yes			No	
	If yes, please provide a description of the deformation							
6.	Nerve Lesion			Yes			No	
	Level: Radial	Upper:		Mid:			Low:	
	Level: Ulnar	Upper:		Mid:			Low:	
	Level: Median	Upper:		Mid:			below:	
	Attach the EMG report:							
7.	Power strength:							
8.	Vascular lesion:			Yes			No	
	Radial			Ulnar				
9.	**Range of movement (ROM):**							

	Elbow	**Measured ROM (Ankylosed joint fixed degrees) e.g. (0-150)**	**COMMENTS**
	Flexion		
	Extension loss		
	Pronation		
	Supination		
10	Radiology Report: please provide the latest radiology report		
11	Other Comments		

I certify that I have examined and satisfied myself that the impairment of the employee is the result of the accident as per first medical report

DECLARATION	
I hereby declare that the information furnished in this report is true and correct according to my knowledge.	
Initial & Surname:	Practice No
E-mail:	Tel:
Signature:	Date:

Please attach Dr's stamp and signature