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

2nd Floor Oxford & Glenhove, 114 Oxford Rd, Houghton Estate, 2198 - Private Bag 87109, Houghton, 2041
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FINAL MEDICAL REPORT

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 AS AMENDED

Provide information for general final occupational diseases diagnosis, where ***necessary please attach an independent report.***

EMPLOYEE DETAILS

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

1.	From what date has the employee been fit for his/her work?	Date:			
	From what date has the employee been fit to work in the open labour market?	Date:			
2.	Was the employee required to change his/her occupation following the medical advice?	Yes		No	
If yes, please provide reasons					
3.	Has there been any permanent loss of function which resulted from the occupational disease?	Yes		No	
If yes, please give a detailed description of the permanent loss supported by evidence of special examination where necessary:					
3.	Has the employee condition stabilised?	Yes		No	
If yes, please give a detailed description of any permanent anatomical defect and/or impairment of functions of the occupational disease.					

DECLARATION	
I hereby declare that the information furnished in this report is true and correct according to my knowledge.	
Intial and Surname:	Initials
E-mail:	Tel:
Signature:	Date: