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

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COID AMPUTEE / PROSTHESIS ASSESSMENT

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

Claim Number _____ Date of Accident _____ Staff number _____
Employer _____
Employee _____

Assessed by _____ Date _____

Details of Amputee

Title _____ First name _____ Surname _____

Postal address _____

_____

_____ Postal code _____

Tel (h) _____ Tel (w) _____ Cell _____

Age _____ Weight _____ Height _____

Current employer _____

Current job description _____

_____

_____

Describe actions of mobility while at work that may be affected by the type of prosthesis fitted.

_____

_____

_____

How often does patient wear prosthesis?

- ☐ Every day
- ☐ Occasionally
- ☐ Seldom

How long does patient wear prosthesis every day?

- ☐ All day
- ☐ Most part of day
- ☐ Less than half of day

Do conditions exist that affect prosthetic mobility?

If yes, describe them briefly

Medical _____

_____

Psychological _____

_____

Environmental _____

_____

Remarks _____

_____