ANNEXURE C

WCL.4 – FIRST MEDICAL REPORT

(ii) COMPLETION OF FIRST MEDICAL REPORT (WCL.4)

- This form must be completed by the medical practitioner/specialist treating the injured employee, and sent to this office. Many problems are currently being experienced as medical practitioners/specialists often do not provide all their details on the WCL.4 forms. This causes unnecessary delays as the forms have to be referred back to the medical practitioners/specialists concerned for correct completion.

- Once a WCL.4 form has been completed, the case must be dealt with as an occupational injury and the accounts for such treatment must not be submitted to the medical aid scheme for payment. In terms of the Compensation for Occupational Injuries and Diseases Act, Act 130/1993, no accounts arising from an occupational injury may be submitted to the injured employee's medical aid scheme for payment.

labour

Department:
Labour
REPUBLIC OF SOUTH AFRICA

Claim Number: .....

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 .....

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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)** .....

.....

.....

.....

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

.....

.....

.....

5. X-rays Date ..... By whom .....
(Attach report if available)
6. Surgical Procedures: Date ..... By whom .....
   Brief description .....

.....

7. Anaesthetics: General / Local ..... Duration .....
6. (a) Consultation Yes / No ..... With whom ..... Date .....
   (b) Was the employee referred for physiotherapy? Yes / No ..... Physiotherapist .....
6. (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 .....

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

Call Centre No.: 086 010 5350 - Fax No.: (012) 323-8627 or (012) 323-6986
E-mail: cf-info@labour.gov.za - Website: www.labour.gov.za