ANNEXURE B

APPLICATON FORM TEMPORARY INCAPACITY LEAVE

LONG PERIOD

IMPORTANT

1 This application form must be completed in respect of incapacity leave periods of **30 working days or more.**

2 This form comprises six parts, i.e. Parts A to F. The employee must complete Parts A and B. The employee's attending doctor must complete Part C. It is the employee's responsibility to have the said part completed by the doctor. Parts D to F are for official use.

3 Please ensure that this form is duly completed, signed and accompanied by all the required supporting documents, as missing or omitted information will delay finalisation of the application. Please also refer to the *Determination on Leave of Absence* for the requirements in respect of medical certificates.

4 This application is subject to an investigation in terms of the *Determination on Leave of Absence*, read together with the *Policy and Procedure on Incapacity Leave and Ill-health Retirement.* In the light hereof, the Employer shall grant temporary incapacity leave **conditionally** for a maximum period of 30 working days with full pay subject to the outcome of the said investigation. Please note that if this application is declined based upon the outcome of the investigation the period of temporary incapacity leave shall be converted to either annual leave or be unpaid leave.

5 Cognisance must also be taken of the fact that the employee is responsible to prove to the Employer's satisfaction that s/he is too ill/injured to be at work. The employee is therefore and in keeping with the principles contained in item 10 of Schedule 8 of the Labour Relations Act, 1995, afforded the opportunity to submit together with his/her application additional medical evidence related to the medical condition of the employee, such as medical reports from a specialist, blood test results, x-ray results, scan results, etc. or any additional motivation/evidence which the employee deems relevant and which supports and states his/her case and which the employer should take into account in contemplating the application for incapacity leave.

6 This application form and supporting documentation is classified as 'Confidential 'in terms of the Minimum Information security Standards.

FOR HEALTH RISK MANAGER'S USE	
Employee Name	
PERSAL NO	
Unique case number	
Incapacity Leave Period	

PART A: EMPLOYEE'S APPLICATION FOR TEMPORARY INCAPACITY LEAVE

1. PARTICULARS OF APPLICATION																									
Surname										**First names**															
Date of Birth										**ID No**															
PERSAL NO										**Gender**	**Female**		**Male**												
Shift Worker	**Yes**		**No**							**Casual Employee**	**Yes**		**No**												
Address during Absence																									
Contact numbers	**@ home**									**@ work**										**Cell phone**					
Period of Absence	**Start date**													**End date**											

2. DETAILS ON CURRENT OCCUPATION			
CURRENT OR MOST RECENT JOB			
Job Title			
Department currently employed			
Commencement date of employment in your current Department		**Number of month/years**	
Commencement date of employment within the Public Service (if an earlier date than above)		**Number of month/years**	
How long have you been in your current job? (months/years)			

Have you held any other posts in the Public Service (Yes/No)		
If Yes, please name the post/job and describe the functions required in the columns below. Enter periods employed in each position.	**Date from**	**Date to**

3. DETAILS OF EDUCATION AND TRAINING

3.1 Please give details of your highest level of schooling, as well as post-school education and any training (academic, technical, in-service, etc.). Also include any on-the-job or in-service training received (during the current or any previous employment either within or outside the Public Service).

Year Qualified	Institution	Qualification

3.2 Considering your training and experience, for what alternative job(s) do you consider yourself eligible <u>within</u> your current department?
3.3 Are any of the above job(s) available in your current department?
3.5 Considering your training and experience, for what alternative job(s) do you consider yourself eligible <u>outside</u> your current department?

4. DETAILS OF OCCUPATION

4.1 Work history:

Apart from your present job, please supply a history of all previous jobs/work within or outside your current department:

From	To	Employer and/or Dept Name	Work position/Occupation

4.2 Duties and Functions of Current Job : Please describe your current duties and functions

4.3 Describe the physical demands of your current job

4.4 Describe the mental demands of your current job

4.5 Describe the tools, equipment and materials used to perform the job

5. DETAILS OF YOUR DISABLEMENT

5.1 Describe in your own words the illness/injury that has given rise to this application – specifically the symptoms/impairments that disable you, and not merely the medical diagnosis:

5.2 Please state the reasons that you consider yourself disabled and unable to function in your current post:

5.3 To the best of your knowledge what has resulted in your current condition? (Please include the specific diagnosis/diagnoses)

6. DETAILS OF MEDICAL CARE

6.1 When did you first consult a medical doctor, clinic or hospital in connection with the above?

Name of Doctor, Clinic or Hospital		**Date**	
Specialty or Department		**Tel No. & Code**	
Address			

6.2 Details of your usual family/general practitioner, clinic or hospital

Name of Doctor, Clinic or Hospital		**Tel No. & Code**	
Address			
Date of last consultation			

6.3 Please give the names of Doctors, Specialists, Clinics, Hospital and other Health Care Professionals you have consulted in the past 3 years :

Name of Doctor, Clinic or Hospital	Specialty or Department	Dates(s) consulted	Diagnosis	Treatment/ surgery undergone	Address and tel. no.

6.4 Please give the details of any Hospitalisation in the past 5 years

Name of Hospital	Reason for admission	Date admitted	Date discharged	Relevant Doctor's Name	Address and tel. no.

7. DETAILS OF THE IMPACT OF YOUR HEALTH CONDITION ON WORK PERFORMANCE

7.1 Details of other concurrent or past illnesses/injuries which you feel contribute to your alleged incapacity

7.2 List and detail the work duties which you are not able to perform

7.3 Describe the specific difficulties you are experiencing in performing your duties

7.4 Do you think you will be able to return to your present job? Yes/No		**If yes, full or part-time**	

If not, why? Please elaborate:
7.5 Detail any alternative jobs (within or outside your current Department or in self-employment) you have performed since you became ill/injured

7.6 Detail any other jobs or income producing activities you may be able to perform in future (within or outside your current Department)

8. DETAILS THE IMPACT OF YOUR HEALTH CONDITION ON OTHER FUNCTIONS *Describe the practical implications of your illness/injury on the following activities of daily living*:
8.1 Mobility (standing, walking, sitting, bending, carrying, etc.)
8.2 Self-care (eating, dressing, bathing, etc.)

8.3 Home management (domestic chores, gardening, shopping, home maintenance, etc.)

8.4 Transport (driving, use of public transport, etc.)

8.5 Sport and recreational activities

8.6 Other

9. DETAILS OF OTHER INCOME/COMPENSATION

Have you received / are you receiving / do you expect to receive any benefit, salary or income from other sources, such as insurance companies, pension, provident or retirement fund, any state fund, compensation for occupational injuries and diseases, a business venture or any other source?

Source	Amount	Date of first payment	Expected period of payment

10. Check list of medical proof/evidence/documentation to be attached	Please Tick
Medical certificate (compulsory)	
Medical report(s)	
Blood tests, x-ray results, scan results, etc.	
Additional written motivation	

DECLARATION	*I hereby declare and warrant that the information given is factual, true and correct, and that no material information has been withheld or any relevant circumstances omitted. Any falsification of information in this regard may form grounds for disciplinary action. I understand that the burden of proof of my illness/injury rests with me and that I am afforded the opportunity to submit additional medical evidence and motivation to this effect with this application. I do understand that if I fail to do so that it would be of my own choice and that the ommission of such information may impact upon the decision regarding my application.*		
Employee signature or of person completing form if applicant is unable to do so		**Date**	

PART B: EMPLOYEE CONSENT FORM

Authority

I_____, ID No _____ PERSAL No_____ an employee of _____ (hereafter referred to as "the Employer") hereby authorise any medical practitioner, hospital, institution, clinic, health care provider or any other relevant person that may hold any medical records relating to me and /or any treatment or advice provided to furnish and release to the Employer and the Health Risk Manager any and all details and information, specifically including confidential information, relating to any illness, injury or condition including, without limitation, all clinical records, laboratory results (including blood and other tests), x-rays, records of all prescribed medications and treatments, progress reports and summaries, correspondence between my medical practitioner and any other person who has provided treatment or where I have been a patient or from whom I have received any medical treatment of any nature whatsoever.

I know and understand that by providing this authority I am curtailing my right to privacy and acknowledge and agree that this is necessary and essential for the Employer and/or the Health Risk Manager to consider, inter alia, the provision of incapacity leave and/or ill health retirement benefits.

This authority is limited to such information as may reasonably be required by the Employer for the purpose of considering and evaluating an application for incapacity leave and/or ill health retirement benefits and for no other purpose without my prior written consent.

I hereby authorise the Employer to disclose and make available to the Health Risk Manager any and all information referred to above as well as any other information that may be in the Employers possession, including previous applications for incapacity leave and /or ill health retirement benefits, medical reports, job descriptions and specifications and related records. I further authorise the Health Risk Manager to disclose and make available any of the aforegoing information in its possession to the Employer and /or the Health Risk Manager.

I confirm that a photocopy of this authority shall be as effective and valid as the original.

Consent to Undergo Medical Examination

I acknowledge that for the employer to consider and evaluate any application for incapacity and/or ill health benefits, I may be required to undergo medical and/or psychological evaluation and other tests including, without limiting the generality of the afore-going, blood tests, for the purpose of determining the nature, extent and duration of any incapacity or illness suffered by me.

I further acknowledge that the Employer, or its Health Risk Manager, may make appointments on my behalf to attend any required medical or other required evaluation as they may determine on reasonable prior notice to me and that, subject to provision set out below, the costs of any such evaluation shall be the responsibility of the Health Risk Manager. I understand that that if I fail to honour the latter appointment, that the Employer shall recover the fruitless expenditure attached to my non-keeping of the appointment shall be recovered from me.

I undertake to present myself for any appointment timeously and with any and all required documentation and information as advised by the Employer or its Health Risk Manager and agree that in the event that I neglect or fail to attend any appointment without reasonable prior notice to the employer and with acceptable justification, any and all costs or charges that may be incurred consequent on my failure to attend will be payable in full by me on demand by the Employer.

Indemnity

I hereby indemnify the Employer and the Health Risk Manager against any claim of whatever nature, which may be made against them as a result of, or arising from the furnishing of any information as provided for herein.

Signed at_____ on this the _____day of _____ 20___.

Employee's signature/ mark or of person completing form if applicant is unable to do so

Signature of witness 1		**Date**	
Full Name & Surname :			
Tel No. :		**Code**	
Cell No. :			

Signature of witness 2		**Date**	
Full Name & Surname:			
Tel No. :		**Code**	
Cell No. :			

REFUSAL TO GIVE CONSENT

I_____, ID No _____
PERSAL No_____ an employee of the _____
refuse to give consent as required above.

Employee's signature/ mark or of person completing form if applicant is unable to do so

PART C: STATEMENT BY ATTENDING DOCTOR

(THE EMPLOYEE IS RESPONSIBLE TO OBTAIN THIS STATEMENT FROM THE DOCTOR)

1. PARTICULARS OF THE ATTENDING DOCTOR			
Doctor's Name			
Doctor's Address			
Contact numbers	**Telephone**	**Fax**	**Cell phone**

2. EMPLOYEE'S MEDICAL DETAILS	
2.1 How long have you been the employee's doctor?	
2.2 On which date did the employee first consult you in connection with this disability/incapacity?	
2.3 On which date did the employee last consult you in connection with this disability/incapacity?	
2.4 Please provide all consultation dates with the employee in connection with this disability/incapacity.	

2.5 Please provide the diagnosis(es) applicable to this employee and how it disables or incapacitates the claimant

2.6 Please detail the onset and history of the illness and/ or injury.

2.7. Please indicate whether the employee's incapacity was occasioned by any of the following. (More than one answer may be applicable.)	
▪ **Ill-health or disease**	
▪ **Occupational disease**	
▪ **Injury/accident on duty**	
▪ **Injury/accident off duty**	
▪ **Violence off duty**	
▪ **Substance or alcohol misuse**	

▪ **Self inflicted injury**	

2.8 Is the employee's disability/incapacity as a result of an injury on duty or an occupational disease?	**Yes**	**No**

2.9 Please detail any concurrent conditions and how they are impacting on the employee's incapacity.

2.10 Please give details of *all* your consultations with the patient over the last year

Date	Complaint	Treatment	Response

2.11. Please provide details of other medical practitioners consulted or of hospital admissions over the past 5 years.

Dates	Medical practitioner/Hospital	Speciality	Treatment / Surgery

2.12. Describe fully the nature and extent of the *functional impairment/s* which results in the employee's apparent inability to perform his/her normal duties.

2.13 What were the presenting symptoms and when did they first appear?

2.14 Please detail the objective findings, such as blood tests, X-ray reports, ECG's, Echocardiography findings, histology results, etc. PLEASE INCLUDE COPIES OF *ALL* AVAILABLE REPORTS.

2.15. Detail all treatments, including pharmacological treatment and dosages, rehabilitation, counseling, etc. and how successful they have been.

2.16 If no treatment has been initiated do you envisage any form of intervention (e.g. Pharmalogical or surgical) being beneficial in diminishing the degree of functional impairment?

2.17 If applicable, please detail any complications or side effects of treatment instituted.

2.18 Please comment on the patient's response and compliance to all treatment initiated.

2.19. Do you consider the employee's treatment to be optimised?	**Yes**	**No**

If no, please comment and indicate what further treatment you believe could be beneficial.

2.20 Do you believe the employee should undergo further investigations? Please comment.

2.21 Do you believe the employee would benefit from any further surgical procedure? Please comment.

2.22 Do you believe that the employee would benefit from any rehabilitation? Please comment.

2.23 What is the employee's overall prognosis in respect of life expectancy?

2.24 What is the employee's occupational prognosis? Please detail.

2.25 How long do you estimate the present degree of incapacity will last? (e.g. temporary or permanent). In the case of temporary incapacity, please indicate an approximate time period.

2.26 In your opinion, what is the likelihood of any improvement in the employee's condition on a scale of 1 to 10 (where 1 is no improvement and 10 is complete recovery). Please detail the extent and nature of the estimated recovery.

2.27 Do the employee's work duties and/or environment aggravate the illness or injury?	**Yes**	**No**
Please detail		

2.28 List the medical problems affecting the employee's work performance in order of priority/severity and give a brief description of the impact the problem has on specific work requirements

2.29 As far as you are aware, when was the employee last able to perform his/her job?	

2.30 If the patient is temporarily unable to perform his/her occupational duties, when do you expect the patient to be able to perform his/her occupational duties? Please specify if this is only *some* duties or *all* duties

2.31 If the patient is permanently unable to perform his/her occupational duties, please suggest other suitable types of work he/she may be capable of performing

2.32. IMPACT OF ILLNESS AND INJURY
In order that we may assess the claimant's functional ability to perform various occupations and not only his current occupation, it would be appreciated if you could indicate to what extent the claimant is likely to be able to perform each of the following activities. If possible these abilities should be measured relative to what they would have been without the illnesses or injuries under consideration, i.e ignore factors such as intelligence or natural abilities of the claimant.

ACTIVITY, TASK OR FUNCTION:	Relative ability to attend to activity – e.g. impossible, possible subject to great/some pain/discomfort, dangerous to him/herself/others, no limitation	Is this ability likely to improve, deteriorate or remain constant	If possible please estimate the time frame over which any change may take place.
Clerical or administrative work (sedentary occupations)			
Thinking clearly and making decisions			
Interacting with people in the workplace – customers colleagues etc			
Supervising other staff			

Walking (non-strenuous) over level ground			
Walking (strenuous) over uneven ground, climbing (e.g into roofs of houses) working in cramped conditions			
Operating of heavy machinery			
Operating of light machinery			
Carrying heavy weights			
Carrying light weights – including for example mail deliveries			
Driving a light motor vehicle			
Driving a heavy motor vehicle, including graders			
Manual labour, digging holes, pushing barrows etc			
Working in a dusty environment, e.g. a mill or factories working with fibrous material			
Performing limited work in a sheltered environment- e.g. weaving baskets			
Teaching			
Policing			
Guarding			

2.33	**Does the employee use any assistive devices?**	**Yes**	**No**
	If no, could the employee benefit from any assistive device?	**Yes**	**No**
	Please Specify:		
2.34	**Please comment on the employee's general mobility:**		
2.35	**Please add any general comments in respect of this claimant's state of health that will assist the multi - disciplinary team in assessing the validity of this disability/incapacity claim:**		

DECLARATION	***I hereby declare and warrant that the information given above is factual, true and correct and that no material information has been withheld nor any relevant circumstances omitted.***		
DOCTOR'S SIGNATURE		**DATE**	
DOCTOR'S SPECIALITY			
DOCTOR'S NAME **(PLEASE PRINT CLEARLY)**		**TEL NO. & CODE**	

PART D: DECISION ON APPLICATION

APPROVAL BY THE HEAD OF DEPARTMENT
Incapacity leave **conditionally** granted pending the outcome of the investigation in terms of the *Directive on Leave of Absence in the Public Service* and the *Management Policy and Procedure on Incapacity Leave and Ill-health Retirement for Public Service Employees*
Remarks or conditions:

SIGNATURE OF HOD/DESIGNEE **DATE**

PART E: THE DEPARTMENT'S REPORT TO THE HEALTH RISK MANAGER

1. NAME OF DEPARTMENT	(Please tick the appropriate box)		
Western Cape Provincial Administration		National Department	
Northern Cape Provincial Administration		Mpumalanga Provincial Administration	
Eastern Cape Provincial Administration		Limpopo Provincial Administration	
Free State Provincial Administration		North West Provincial Administration	
Gauteng Provincial Administration		KwaZulu-Natal Provincial Administration	

2. PARTICULARS ON THE EMPLOYEE						
Date joined Department/ Public Service					Job title	
Full-time/Part-time					Annual basic salary	
Current physical workplace (city/town)					Level of Education/ training	
On normal sick leave	Yes		No		Last day at work	
On incapacity leave	Yes		No			

3.	**ADDITIONAL INFORMATION ON THE EMPLOYEE**

3.1 **Cause of incapacity**	**Please tick**	**Brief description of illness/injury**
▪ Ill-health		
▪ Accident/Injury on duty		
▪ Accident/Injury off-duty		
▪ Violence off-duty		
▪ Other (please specify)		

3.2 **Is it expected that the employee will recover to the extent of returning to**	**Yes**		**No**		**Uncertain**	

If **no** or **uncertain**, please elaborate:

3.3 **The employee's sick leave record for the current and previous sick leave cycle or attach a PERSAL printout from function #4.5.1 option 5 provided that the PERSAL records are up to date. If necessary, the said information could be supplied on a separate sheet. In such an event the sheet must be attached to this form.**

From	**To**	**Number of working days**	**Reason**

4. CHECK LIST OF DOCUMENTATION TO BE ATTACHED	Please tick
▪ Medical certificate (SUPPLIED BY EMPLOYEE)	
▪ Medical reports (If supplied by employee)	
▪ Blood tests, x-ray results, scan results, etc. (If supplied by employee)	
▪ Additional written motivation (If supplied by employee)	
▪ PERSAL printout of sick leave records of the previous & current sick leave cycles (PERSAL Function #4.5.1 Option 5)	

5. CONTACT DETAILS OF DEPARTMENT (Please provide details of two contact persons)			
Physical address of Department			
CONTACT PERSON IN DEPARTMENT		**Designation**	
Tel no (Code and No)		**Fax no (Code and No)**	
E-mail address			
ALTERNATIVE CONTACT PERSON			
Contact person in department		**Designation**	
Tel no (Code and No.)		**Fax no (Code and No.)**	
E-mail address			

DECLARATION	***I hereby declare and warrant that the information given is to my knowledge factual, true and correct and that no material information has been either withheld or any relevant circumstances omitted.***		
Signature of Head of Department or delegate		**Date**	
Print Name		**Designation**	

PART E: SUMMARY OF HEALTH RISK MANAGERS RECOMMENDATION

(The full report and recommendation is attached)

Periods concerned	**Recommended Yes/No**	**Motivation**
1.		
2		
3		

Signature of HRM		**Date**	
Print Name		**Tel no**	

PART F: DECISION BY THE HEAD OF DEPARTMENT

Approved / Not approved

COMMENTS/CONDITIONS/INSTRUCTIONS

Signature of Head of Department or delegate		**Date**	
Print Name		**Designation**	

ACTIONS	Captured/Executed	Checked & signed off
1.Employee notified of decision		
2. Decision captured on PERSAL		
3.Salary overpayment recovered, if applicable		