

#### ANNEXURE E

# HEAD OF DEPARTMENT'S REPORT TO HEALTH RISK MANAGER FOR ILL-HEALTH RETIREMENT

#### **IMPORTANT**

- This form comprises four parts, i.e. Parts A to D. The employer must complete Part A, the employee must complete Parts B and C and the employee's treating medical practitioner must complete Part D.
- Please ensure that this form is duly completed, signed and accompanied by all the required supporting documents, as missing or omitted information may either delay or detrimentally impact on the finalisation/consideration of the application.
- This application is subject to an investigation in terms of *Public Service Regulation G.3/Part VII/Chapter 1* of the *Public Service Regulations*, read together with the *Policy and Procedure on Incapacity Leave and Ill-health Retirement (PILIR)*.
- Cognisance must be taken of the fact that it is the responsibility of the employee to prove that s/he is too ill to continue working. 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 motivates his/her case and which the employer should take into account in contemplating the application for incapacity leave.
- 5 This application form and supporting documentation is classified as 'Confidential 'in terms of the Minimum Information Security Standards.

FOR OFFICIAL USE	
Employee Name	
PERSAL NO	
Unique case number	



#### APPLICATION FOR ILL-HEALTH RETIREMENT

#### PART A: STATEMENT BY EMPLOYER

1. PARTICULARS OF THE DEPARTMENT									
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	Gauteng Provincial Administration KwaZulu-Natal Provincial Administration								

2. 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 CONTA	ACT PERSON							
Contact person in department		Designation						
Tel no (Code and No)		Fax no (Code and No)						
E-mail address								



3. PARTICULARS OF THE EMPLOYEE TO BE CONSIDERED FOR ILL-HEALTH RETIREMENT																					
Surname	A STATE OF THE PROPERTY OF THE			irst names		*****	- Standard	(0,-10		W. S. P. A. C. S. C.	Navous Arcord	/0.44		CHICAN STANK							
Date of birth									ID Number							and the same of th			COMPANY CONTRACTOR		
PERSAL number									Gender	F	em:	L I				Management of the second	L Ma	le			
Date appointed in the Department							700		Date joined (	ЭE	PF				1900 Marie						
Annual pensionable salary			erronaend	2					Retirement a	ge		Topic Control of the				<u> </u>			<del></del>		
Address								The second secon	ada eta para kanta k							a (e mail a sea a		<b>1000</b>	niecznowy oczne		orthography and the second
Contact Telephone	(a)	hon	ne						@ work				C	'ell	pho	ne					
Numbers			*****																		
																	- Markenson	*********		**********	XIII

4. DETAILS OF EMPLOYMENT										
Job title							anti-strenters of			
Current work status				Full-time/Part- time						
On normal sick leave	YES	NO	N/A	Still working (Yes/No)		YES			NO	ATTENDED CONTINUE
On incapacity leave	YES	NO	N/A	Last day at work		\$500 may 100 ma				

(Note: Please attach a detailed job description)



5.	LIST THE EMPLOYEE'S KEY PERFORMANCE AREAS OR REGULARLY PERFORMED WORK DUTIES WITH A BRIEF DESCRIPTION OF EACH.					
6.	JOB REQUIREMENTS:					
6.1	TYPE OF DUTIES	% OF TIME SPENT PERFORMING				
	Sedentary work					
	Manual work					
	Commercial work (buying/selling)					
	Supervision or inspection					
	Other: specify					
6.2	WORK ENVIRONMENT	% OF TIME SPENT WORKING IN				
	Office or administrative environment					
	Factory or industrial environment					
	Outside					
	Driving					
	Other: specify					



6.3	EXPOSURE TO ADVERSE CONDITIONS	Exposed to (yes/no). If yes, describe
	Extreme temperatures	
And the second	Noise	
1000110011001100	Dust	
0.000	Fumes	
	Heights/depths	
	Rough terrain	
	Other hazards: specify	
6.4	Specify machinery, equipment, tools and mate	erials being used



77	PHYSICA	E. R. P. B. L. B.	TABLES A. B.
1.		8 , 8 8 87 , 9	VB /4 19 11 2 7

# 7.1 Complete the table below indicating the amount of time spent on the following activities:

ACTIVITY	NEVER	SOMETIMES	OFTEN	CONTINUOUSLY
Standing				
Walking				
Sitting				
Using hands to finger, handle, or feel				
Reaching with hands and arms				
Climbing and balancing				
Stooping, kneeling, crouching, or crawling				
Bending				
Lifting and carrying				
Pushing and pulling				
Hearing essential				
Visual acuity essential				

# 7.2 Indicate the amount of time spent exerting force to lift, carry, push or pull weights

FORCE/WEIGHT	NEVER	SOMETIMES	OFTEN	CONTINUOUSLY
0 to 5 kg				
5 to 15 kg				
15 to 30 kg				
30 to 50 kg				
More than 50 kg				



8.	Mental	demands
U.	1.7 1. 5. 11 1. 221	CECTIFICATION

8.1 Indicate how much of the employee's job requires the following abilities and tick the level of ability required

ABILITIES	NEVER	SOMETIMES	OFTEN	CONTINUOUSLY
Verbal communication				
Written communication				
Calculations/mathematical				
Memory	111			And the second s
Following instructions				
Giving instructions				
Planning				
Problem solving				
Decision making				
Work under pressure				
Other, specify:				

9. DETAILS OF INCAPACITY/DISABLEMENT								
CAUSE OF THE INCAPACITY	Please Tick	DATE OF ONSET AND BRIEF DESCRIPTION						
Ill-health								
Injury on duty / Arose out of discharge of official duties								
Accident / injury off-duty								

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		Wikindowski program pr								
Violence of	f-duty									
Other										
	E.									
10 COM	10 COMPLETE THE EMPLOYEE'S SICK LEAVE RECORD FOR THE LAST 2 YEARS									
From	То	Number of working days	Reason							
THE	NO ASSELLATION OF THE PROPERTY									
		Alexander of the second								
11. Describe the impact of the illness/injuries on the employee's work abilities, with reference to specific work duties and environmental factors										

APPLICATION FORM ILL-HEALTH RETIREMENT



12. Describe any other employee's difficultie	factors, either at work or outside work, which could be contributing to these in performing his/her work duties satisfactorily
13. Is it expected that the	e employee will recover to the extent of returning to work?  YES  NO
If yes, specify below:	
Same job	
Adapted job	
Alternative job	
Expected date of return	Full-time/Part-time capacity
work environment an	made to accommodate the employee's impairment/s or incapacity by adapting the duties, or by placing the employee in an alternative work position



15. List alternative jobs in the Department which the employee may be able to perform in future, together with a brief description.							
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	overstill de la committe que est a est a committe en casa se a committe de propositiva de la committe de la co	NAV VITS 4 CCC NO DE COCCOCA NO ELE BER DE MANS AND PRIME QUANTIFICATION (A PRIME AND	A THE STATE OF THE PARTY AND THE STATE OF TH	ang			
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16. Details of benefits from other	ner sources as a result	of incapacity (current a	nd anticipated)				
Source	Amount	Date of first payment	Period of pay	ment			
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			Parliet P. Lean Grant Control of the Action (Control of Action (Contro				
17. CHECK LIST OF DOC	UMENTATION TO F	BE ATTACHED	ASSA TATA SECURIO DE LA CASA DE L	Please tick			
Medical reports (SUPPLIED BY EMPLOYEE)							
Blood tests, x-ray results, scan results, etc. (SUPPLIED BY EMPLOYEE)							
Additional written motivation (S	Additional written motivation (SUPPLIED BY EMPLOYEE)						
PERSAL printout of sick leave records of the previous & current sick leave cycles (PERSAL Function #4.5.1 Option 5)							
A certified copy of the employee	's ID						



DECLARATION	I hereby declare that the employee has been informed of the conditions of the Fund rules concerning ill-health benefits.  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 B:

# STATEMENT BY EMPLOYEE

1. PERSONAL PARTICULARS																							
Surname	Surname																						
First names	st names																						
Date of birth			Transmission of the last of th						ID	No.													
PERSAL nu	mber		(				Xula hara dalah																
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2. DETAI	LS OF E	DUCA	TI(	ON A	AND	TR	AI	NIN	G														
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	A STATE OF THE STA	317,3310									ETEROS NO.												



3 DETAILS OF OCCUPATION										
3.1 Work publi	3.1 Work history: Apart from your present job, please supply a history of all previous jobs in both the public and private sector									
From	То	Department / Company		Work position/Occupation						
	CONTRACTOR OF THE PROPERTY OF									
			**************************************							
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3.2 Curre	nt or most rec	ent job	Anthony and a second							
3.2.1	Job designatio	n								
3.2.2	Department / o	enter								
3.3 Please	fully describe	your duties and function	3							
HOUSE AND										



<u> </u>	
3.4	Describe the physical demands of the job
3.5	Describe the mental demands of the job
3.6	Describe the tools, equipment and materials used to perform the job



4. DETAILS OF DISA	4. DETAILS OF DISABLEMENT							
4.1 Describe the illness.	4.1 Describe the illness/injury that has given rise to this application							
4.2 When did you first consult a medical doctor in connection with the above?								
Name of Doctor		Date						
Speciality		Tel No & Code						
Address	CONTRACTOR							
4.3 Details of your usual	l family / general practitioner							
Name of Doctor		Tel No & Code						
Address								
restrendam regisjonisti vede deklaka nje štutu na naskozum se orusina u daka kralja opokranja kolono u suprav								
Date of last consultation								



	ide san					
4.4	Ple: con	ase give th sulted or at	e names of doctor ttended in connectio	s, specialists, ot n with your inca	her health professio pacity	nals and hospitals you have
Fron	1	То	Doctor / hospital / or other	Speciality	Tel. No and Code.	Treatment/surgery received
WHO IN WATER						
		to commence and the second				
4.5	Deta inca	ils of othe pacity	r concurrent or pa	st illnesses/injuri	les which you feel m	ay have contributed to your
	<del></del>					
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5.	DET	AILS OF T	THE IMPACT OF Y	OUR HEALTH	CONDITION ON V	VORK PERFORMANCE
5.1	Deta incap	ils of other pacity	concurrent or pas	t illnesses/injurie	es which you feel ma	y have contributed to your
					The second secon	



5.2	List the work duties which yo	ou are not able to perform		
************				
5.3	Describe the specific difficulti	es you are experiencing in pe	rforming vour du	fies
	and the second s	Cracination (Cracination) (Cracination of Cracination (Cracination) (Cracination) (Cracination) (Cracination)	ORA SI ORA MANAGAMAN	BROCK COCK (LLT KKUR) BRAKEN (F. 1746) BRAKEN (F. 1747) BRAKEN (F. 1746) BRAKEN (F. 1746) BRAKEN (F. 1746) BRAKEN (F. 1746)
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5.4	When will you be able to		Full / part-time	
	return to your present job?		capacity	
If no	t able to resume your present jo	ob, what alternative jobs coul	d you perform wi	thin Department
<u> </u>				



-	
5.5	Detail any alternative jobs (within or outside the Department or in self-employment) you have performed since you became ill/injured
20022	
5.6	Detail any other jobs or income producing activities you may be able to perform in future
and the same of th	
6.	DETAILS OF IMPACT OF YOUR HEALTH CONDITION ON OTHER FUNCTIONS
6.1	Describe the practical implications of your illness/injury on the following activities of daily living:
	6.1.1 Mobility (standing, walking, sitting, bending, carrying, etc.)



6.1.2 Self-care (eating, dressin	g, bathing, etc.)	
No.		
6.1.3 Home management (dom	nestic chores, gardening, shopping, home maintenance, etc.)	
6.1.4 Transport (driving, use o	f public transport, etc.)	
6.1.5 Sport and recreational ac	tivities	
		,
6.1.6 Other		The state of the s



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7.	DETAILS O	FOTHER	INCOMP/COMPENSATION	Ĭ

7.1 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

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

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 C: EMPLOYEE CONSENT FORM

Authority						
I			, ID	No		
PERSAL No	an em	ployee of				(hereafter
referred to as "the Em	ployer") hereb	y authorise any	medical pra	ctitioner,	hospital, in	stitution, clinic,
health care provider or	any other relevan	nt person that n	nay hold any r	nedical re	cords relatin	ng to me and /or
any treatment or advice	provided to fun	nish and release	to the Emplo	oyer and /	or the Healtl	h Risk Manager
any and all details and	information, spec	cifically includi	ng confidenti	al informa	ition, relatin	g to any illness,
injury or condition incl	luding, without l	limitation, all c	linical records	s, laborate	ory results (i	including blood
and other tests), x-ray	s, records of a	ll prescribed n	nedications a	nd treatm	ents, progre	ess reports and
summaries, correspond	ence between n	ny medical pra	ctitioner and	any other	person wh	o has provided
treatment or where I h	ave been a patie	ent or from who	om I have red	ceived an	y medical tr	reatment 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 representatives 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 if I fail to honour the latter appointment, that the Employer shall recover the fruitless expenditure attached to my non-keeping of the appointment 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 its 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 unless such claim or furnishing of my information provided herein arose from or is as a result of any willful or negligent act of the Employer, its employees and its Health Risk Manager and its agents.

Signed at	on this the	day of		20	
Employee's signature/ mar completing form if applicant is t					
Signature of witness 1	and Machine entire Declines to make a make a product to a decline and a make a part of the second and a make by	- Inches	Pate		<del>n Carlon (CAR) (A SPECIAL PROCESSOR) (Processor) (Pro</del>
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Tel No. :			Code		
Cell No. :					
Signature of witness 2			Date		
Full Name & Surname:					
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REFUSAL TO GIVE CONSENT					oministrative mentions and an experience and an
I No an employee required above.	of the	, ID N	lo	refuse to giv	PERSAL re consent as
Signed at	on this the	_day of		20	
Employee's signature/ mark completing form if applicant is un					



Signature of witness 1	Date	
Full Name & Surname :		Reception of the families are not as the first of the order of the families of the contract of the families of
Tel No. :	Code	
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Signature of witness 2	Date	
Full Name & Surname:		
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## PART D: STATEMENT BY ATTENDING DOCTOR

1. Particulars of the employee (to be completed by the department)							
Surname First Names							
Date of Birth		remental de la companya de la compa	ID No				
Department			Occupation				
PERSAL Number							
Main job functions							
2. PARTICULA	RS OF	THE ATTENDING DOC	TOR				
Doctor's Name		beautimister and the state of t					
Doctor's Address	Annual Parallel Section (Section 1)		nation in 19 about ing acceptant and the analysis and the acceptance and acceptan	diche bedaran kon anno premiaren Dicker ora grand frank untere biorist drei dat bezet dicher brown a vez ora concomi			
Contact numbers		Tel. No and Code	Fax No and Code	Cell phone			
3. MEDICAL DE	ETAILS						
3.1 Date of first consultation							
3.3 Main diagnosis	s and car	use of disablement					
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3.4	Detail the onset and history	of the illness/injury					
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3.5	Opinion as to whether the in	ncapacity was occasioned by					
	Ill-health						
	Injury on duty / Arose out of discharge of official duties						
	Accident / injury off-duty						
	Violence off-duty						
	Other						
3.6	Concurrent conditions, if an	у					
	iaran 1888 ka sa ka s						
er namer red medical I de spilots							
*******************************							



Date	Complaint		3.7 Please give details of your consultations with the patient over the last year					
	Date Complaint Treatment Response							
Modelium blessier for beniers of principal music consequences.				<del>-500-10</del>				
				21000000				
3.8 Detai	lls of the last clinical e	valuation						
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3.9 Detai result		uch as blood tests, X-ra	y reports, ECG's, echocardiographs and histological	39				
PLEASE IN	NCLUDE COPIES OI	AVAILABLE REPOR	rs					
	n de la companya de l							
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				2072507				



5.10 Describe the nature and extent of the functional impairment/s				
			DAN ENGLISH OF THE TRANSPORTATION OF THE TRA	
			rendere de la companya	************
3.11 Does the patient's work du	3.11 Does the patient's work duties and/or environment aggravate the illness or injury? Yes No			
If yes, describe			garanteenan in anna reastaire (reastaire (reastaire (reastaire (reastaire (reastaire (reastaire (reastaire (re	
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межения повет в настройных и тер за подателения и почет почет в подателения почет в подателения на почет в поч				
3.12 Please provide details of other medical practitioners consulted or of hospital admissions over the past 5 years				past 5
Dates	Medical practitioner/Hospital	Speciality	Treatmen Surgery	t /
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3.13	Please provide details of present treatment, including medication and counseling, etc.	dosages,	rehabilitation,
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3.14	If applicable, please detail any complications or side effects of treatment		
		anna dha ann a tha ann an t-ann an t-a	
3.15	Please comment on the patient's response and compliance to current treatmen	ť	
l Marianta de la companio de la comp			
		Activities (* <u>1985) en de l'Adrigo en de Article en de Ar</u>	
and managed and an account 18			



3.16	Please provide details of all treatment over the last 3 years
3.17	What further treatment, procedures or investigations would you recommend?
70 - 10110 - 2004 - 200 - 10110 - 2004 - 2004 - 2004	
3.18	What further rehabilitation is envisaged for the patient?



Secondaria de la constanta de			
3.19	Prognosis		
***************************************			
4.	WORK ABILITY		
4.1		ems affecting the patient's work performance (in order of priority), with a brief act the problem has on specific work requirements	
	oppress of the group of the good operated decrease in the advanced as the constant and the constant and advanced to the constant and the const		
4.2	4.2 When was the patient last able to perform his/her job?		
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 again? Please specify			
Some	duties		
All du	ties		



4.3	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
4.4	Opinion as to whether longevity or life expectancy is affected
alaman de francisco de la composición	
	Other comments regarding the patients state of health which may assist in the assessment of this neapacity application
William Willia	



DECLARATION	I hereby declare and warrant that the information given above is factual, true and correct and that no material information has been neither withheld nor any relevant circumstances omitted.		
DOCTOR'S SIGNATURE		Date	
DOCTOR'S SPECIALITY		Tel. No and Code	
DOCTOR'S NAME (PLEASE PRINT CLEARLY)		Qualifications	
DOCTOR'S ADDRESS			