ANNEXURE E

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

IMPORTANT

1 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.

2 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.

3 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).*

4 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		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 CONTACT 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			First names				
Date of birth			ID Number				
PERSAL number			Gender	Female		Male	
Date appointed in the Department			Date joined GEPF				
Annual pensionable salary			Retirement age				
Address							
Contact Numbers Telephone	@ home		@ work		Cell phone		

4. DETAILS OF EMPLOYMENT						
Job title						
Current work status				Full-time/Part-time		
On normal sick leave	YES	NO	N/A	Still working (Yes/No)	YES	NO
On incapacity leave	YES	NO	N/A	Last day at work		

(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	
Noise	
Dust	
Fumes	
Heights/depths	
Rough terrain	
Other hazards: specify	

6.4 Specify machinery, equipment, tools and materials being used

7. PHYSICAL DEMANDS

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

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				
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		

Violence off-duty		
Other		

10 COMPLETE THE EMPLOYEE'S SICK LEAVE RECORD FOR THE LAST 2 YEARS			
From	To	Number of working days	Reason

11. Describe the impact of the illness/injuries on the employee's work abilities, with reference to specific work duties and environmental factors

12. Describe any other factors, either at work or outside work, which could be contributing to the employee's difficulties in performing his/her work duties satisfactorily

13. Is it expected that the 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	

14. Describe any efforts made to accommodate the employee's impairment/s or incapacity by adapting the work environment and 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.

16. Details of benefits from other sources as a result of incapacity (current and anticipated)			
Source	Amount	Date of first payment	Period of payment

17. CHECK LIST OF DOCUMENTATION TO BE ATTACHED	Please tick
Medical reports (SUPPLIED BY EMPLOYEE)	
Blood tests, x-ray results, scan results, etc. (SUPPLIED BY EMPLOYEE)	
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			
First names			
Date of birth		ID No.	
PERSAL number			
Residential address		Postal address	
Telephone numbers:			
@ work (Code and No)		@ home (Code and No	
Alternative contact number		Cell No	
E-mail address			

2. DETAILS OF EDUCATION AND TRAINING
2.1 Please give details of your highest level of schooling, post-school education and training (academic, technical, in-service, etc.)

Year	Institution	Qualification

3 DETAILS OF OCCUPATION

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	To	Department / Company	Work position/Occupation

3.2 Current or most recent job

3.2.1 Job designation	
3.2.2 Department / center	

3.3 Please fully describe your duties and functions

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 DISABLEMENT
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			

4.3 Details of your usual family / general practitioner			
Name of Doctor		Tel No & Code	
Address			
Date of last consultation			

4.4 Please give the names of doctors, specialists, other health professionals and hospitals you have consulted or attended in connection with your incapacity					
From	To	Doctor / hospital / or other	Speciality	Tel. No and Code.	Treatment/surgery received

4.5 Details of other concurrent or past illnesses/injuries which you feel may have contributed to your incapacity

5. DETAILS OF THE IMPACT OF YOUR HEALTH CONDITION ON WORK PERFORMANCE
5.1 Details of other concurrent or past illnesses/injuries which you feel may have contributed to your incapacity

5.2 List the work duties which you are not able to perform

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

5.4 When will you be able to return to your present job?		Full / part-time capacity	

If not able to resume your present job, what alternative jobs could you perform within Department

5.5 Detail any alternative jobs (within or outside the Department or in self-employment) you have performed since you became ill/injured

5.6 Detail any other jobs or income producing activities you may be able to perform in future

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, dressing, bathing, etc.)
6.1.3 Home management (domestic chores, gardening, shopping, home maintenance, etc.)
6.1.4 Transport (driving, use of public transport, etc.)
6.1.5 Sport and recreational activities
6.1.6 Other

7. DETAILS OF OTHER INCOME/COMPENSATION
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 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 /or 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 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/ mark 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.

Signed at_____ **on this the** _____**day of** _____ **20**___.

Employee's signature/ mark 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. :			

PART D: STATEMENT BY ATTENDING DOCTOR

1. Particulars of the employee (to be completed by the department)			
Surname		First Names	
Date of Birth		ID No	
Department		Occupation	
PERSAL Number			
Main job functions			

2. PARTICULARS OF THE ATTENDING DOCTOR			
Doctor's Name			
Doctor's Address			
Contact numbers	Tel. No and Code	Fax No and Code	Cell phone

3. MEDICAL DETAILS			
3.1 Date of first consultation		3.2 Date of last consultation	
3.3 Main diagnosis and cause of disablement			

3.4 Detail the onset and history of the illness/injury

3.5 Opinion as to whether the incapacity 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 any

3.7 Please give details of your consultations with the patient over the last year			
Date	**Complaint**	**Treatment**	**Response**

3.8 Details of the last clinical evaluation

3.9 Detail objective findings, such as blood tests, X-ray reports, ECG's, echocardiographs and histology results. PLEASE INCLUDE COPIES OF AVAILABLE REPORTS

3.10 Describe the nature and extent of the functional impairment/s

3.11 Does the patient's work duties and/or environment aggravate the illness or injury?	Yes	No

If yes, describe

3.12 Please provide details of other medical practitioners consulted or of hospital admissions over the past 5 years			
Dates	**Medical practitioner/Hospital**	**Speciality**	**Treatment / Surgery**

3.13 Please provide details of present treatment, including medication and dosages, rehabilitation, counseling, etc.

3.14 If applicable, please detail any complications or side effects of treatment

3.15 Please comment on the patient's response and compliance to current treatment

3.16 Please provide details of all treatment over the last 3 years

3.17 What further treatment, procedures or investigations would you recommend?

3.18 What further rehabilitation is envisaged for the patient?

3.19 Prognosis

4. WORK ABILITY
4.1 List the medical problems affecting the patient's work performance (in order of priority), with a brief description of the impact the problem has on specific work requirements

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 duties	

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

4.5 Other comments regarding the patients state of health which may assist in the assessment of this incapacity application

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			