

ANNEXURE A

APPLICATION FORM: TEMPORARY INCAPACITY LEAVE SHORT PERIODS

IMPORTANT

- This application form must be completed in respect of an incapacity leave period of less than 30 working days.
- 2 This form comprises six parts, i.e. Parts A to F. The employee must complete Parts A and B. Parts C to F are for official use only.
- 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. You are reminded that the submission of a medical certificate with each application is mandatory. Please also refer to the *Determination on Leave of Absence* for the requirements in respect of medical certificates.
- 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 29 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.
- 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.
- 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	
Incapacity Leave Period	



APPLICATON FORM TEMPORARY INCAPACITY LEAVE: SHORT PERIOD

PART A: EMPLOYEE'S APPLICATION FOR TEMPORARY INCAPACITY LEAVE

PARTICULARS OF	PARTICULARS OF APPLICANT																						
Surname				Shank	Service		No.	Fi	irs	t names		W. 67 5-110-1-1-1						***************************************		SEWS	\$200	of in Standard	
Date of Birth										ID No								The second second			200 COLUMN 1	1	
PERSAL NO										Gender	F	'em:	ale	licourum S		milimensu 	Serven		Ma	le		alleesse	allesee
Shift Worker		Yes	1			No		9001Fiction		Contract	Eı	mpl	oye	e		Ye	s		*******		No		
Address during Abse	ence		**************	***	***************************************			- tricing								- Marie Park	- TOTAL LICENSE	- Constitution of the Cons			Wante and the second	200	SECONDA SECOND
Contact numbers	@	hom	e		Na American	W	ZEAST		a	work	Same.			Oleman and a second	(Cell	ph	101	ne	District Control of the Control of t	Nonetta senem	THE STATE OF THE S	MISSINGHA
										PLACE OF THE STATE												W. (100 TM)	FEEE - LEGATE
Email Address									_												Alexandra de la constanta de l		Comm
Period of Absence	Sti	Start date End date																					
CHECK LIST OF M ATTACHED	EDICAI	LEV	IDE	NCI	E OJ	R AI	DI	TI(ON	IAL MOT	ΊV	ΆΤ	IO:	NT	O.	BE				Tools.	ick'		
Medical certificate (c	ompulso	ry)	NATURAL DESIGNATION DE LA CONTRACTION DE LA CONT	4			h-marking in the				200000	***************************************				4/20-20-20-20-20-20-20-20-20-20-20-20-20-2		and the same of				Ti National	Discount.
Medical report(s)					www.montes	**************************************	onesone soci	MESSALISADULUS								-							
Blood tests, x-ray res	ults, scar	ı resi	ults,	etc.	monumone	OFFICE OF STREET	200000000000000000000000000000000000000					in the second	alaharasan.	V6520004-V6604	www.moco			nu:con			overmouses	MANAGE CECHO	
Additional written m	otivatior	i			***************************************	ananan salakan		NUMBER OF STREET			lan red rayings	ationamical to tax			ectrision				WWW.		terres and the same		
A CONTRACTOR OF THE PROPERTY O	annocentaria comenza	Manage Marie	пониодине	erannenen erannen	lansmarktvistakt.	www.compress	inemistes	September 1		SALES MINISTRAÇÃO	- Auto-	maranay, adam	major at	*(************************************		alin Personni II.	West comes	SOLOTON	опистем.	antonien.	iaroumone.	te du even	.manuser
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 shmit 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.								ny . I am ect wn															
Employee signature of person completing form if applicant is unable to do so			·							Date				Month and the second se									



PART B: EMPLOYEE CONSENT FORM

Authority		
I ,	ID	No
PERSAL No	an	employee of
	"the Employer") hereby	
medical practitioner, hospital, institution, clinic, health care provide	r or any other relevant p	erson that may
hold any medical records relating to me and /or any treatment or advi	ce provided to furnish an	d release to the
Employer and Health Risk Manager appointed by the Employer	any and all details an	id information,
specifically including confidential information, relating to any illnes	s, injury or condition inc	luding, without
limitation, all clinical records, laboratory results (including blood	and other tests), x-rays,	records of all
prescribed medications and treatments, progress reports and summaria	es, correspondence betwe	en my medical
practitioner and any other person who has provided treatment or whe	re I have been a patient c	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 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.

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 for 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 representatives 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 completing form if applicant is t						
Signature of witness 1		Date				
Full Name & Surname :						
Tel No. :		Code	2		HERO SCHOOL AND	
Cell No. :					n programme graph complexity control to the control	ermikintan kole kitik dominin kita na primining sahiri na minin dia popula sahirina yan dala
Signature of witness 2			Date			
Full Name & Surname:	THE PROPERTY OF THE PROPERTY O			edavina Stronovi (1990)	Constitution of the second	
Tel No.:			Code			
Cell No.:						
REFUSAL TO GIVE CONSEN	XX.					
I_PERSAL No	nn	an	employ	ree	of	the
Signed at	on this the	day of		····	20	
Employee's signature/ mark completing form if applicant is u						





Signature of witness 1	Date			
Full Name & Surname:		ngangangan yang di antanaka kalamatan yang arawa di angkang kapan germangkan arawa		
Tel No.:	Code			
Cell No.:				
Signature of with	iess 2	ngangan sa Apagan ka atau isa atau atau atau atau atau atau atau at	Date	
Full Name & Su	rname:			
Tel No.:		estationismos estationos estationes estationes estationes estationes estationes estationes estationes estation	Code	
Cell No.:				



PART C: DECISION ON APPLICATION

1. COMMENTS BY SUPERVISOR/MANAGER	
Attach a loose page if necessary	
	with the control of t
	REPORTER EN SALESCER MECHANICA EN HOLLE DI MINICO DI TI SONNA ARTONICA CONTROLICA DI ANCIONI DI MANCIONI DI LA SEVENCIONI
SIGNATURE OF SUPERVISOR/ MANAGER	DATE
2. APPROVAL BY THE HEAD OF DEPARTMENT	
Incapacity leave conditionally granted pending the outcome of the Leave of Absence in the Public Service and the Policy and Proceed Retirement (PILIR)	
Remarks or conditions:	



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

		Marie Contract of the Contract					
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	pul					
Free State Provincial Administration	North West Provincial Administration						
Gauteng Provincial Administration	KwaZulu-Natal Provincial Administration						
Administration Eastern Cape Provincial Administration Free State Provincial Administration	Limpopo Provincial Administration North West Provincial Administration						

2. PARTICULARS ON THE EMPLOYEE							
Date joined Departmen Public Service	t/			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			
On incapacity leave	Yes	No		work			

3.	3. ADDITIONAL INFORMATION ON THE EMPLOYEE									
3.1	(Cause of incapacity	Please tick	Brief description of illness/injury						
	B	III-health								
		Accident/Injury on duty								
	E	Accident/Injury off-duty								
	es	Violence off-duty								
	m	Other (please specify)		and the state of t						



em;	t expected tha ployee will rec ent of returni	cover to the	Yes		No		Uncertain	:		
lfn	If no or uncertain , please elaborate:									
						namarak a syning ya serangan sajanda mahinik emilik a synik da da synik da sayak da sajan sa	aliani-makening minga bina langan ang dinangan kang at langan ang dinangan kang at langan minga ba			
						del Maries del Carolido Antonio de La Carolida Ambiesta de Carolida (Carolida de Carolida	alemanika kemula saka saka menjerungan pengengan kemula menjerungan berak saka sakan b	Comment de comment de confession de comment		
atta to d	ch a PERSAl ate. If necess	L printout from	n function i formation (#4.5.1 option	n 5 provi	ded that the	evious sick leav PERSAL record Sheet. In such an	rds are up		
From	From To Number of Reason working days									
					nona de la managamenta de la managament					
					Palanjana ja					
						POLICE STATE OF THE PROPERTY O				
				dankas foliannika sunak zakodna erinamen manana						
COMPANY OF THE PARTY OF THE PAR	HE MINING TO THE TOTAL OF THE T									
4. CH	4. CHECK LIST OF DOCUMENTATION TO BE ATTACHED Please tick							IEI 3		
B	Medical certificate (SUPPLIED BY EMPLOYEE)									
	Medical reports (If supplied by employee)									
z	Blood tests, x-ray results, scan results, etc. (If supplied by employee)									
n	Additional written motivation (If supplied by employee)									
П	PERSAL printout of sick leave records of the previous & current sick leave cycles (PERSAL Function #4.5.1 Option 5)							CONTROL CONTRO		



5. CONTACT DETAI	LS OF DEPARTMENT (Please p	rovide details of two	contact persons)
Physical address of Department			M. Facilities
CONTACT PERSON IN DEPARTMENT		Designation	
Tel no (Code & no)		Fax no (Code & no)	
E-mail address			
ALTERNATIVE CONTA	ACT PERSON		
Contact person in department		Designation	
Tel no (Code & no)		Fax no (Code & no)	
E-mail address	Happen and the control of the contro		
DECLARATION	I hereby declare and warrant to factual, true and correct and to withheld or any relevant circumst	that no material inj	given is to my knowledge formation has either been
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 or delegate	emmenten Ann enter i Pribute y zeptembet i elektrist		Date	
Print Name			Tel no (Code & No)	



PART F: FINAL DECISION BY THE HEAD OF DEPARTMENT

COMMENTS/CONDITIONS/INSTRUCTIONS:

Temporary incapacity leave requested in Part A is approved / not approved.

Section depends per extra de mesta de contra de la Mesta de la colonia d	H H H H H H H H H H H H H H H H H H H			777	A MACHINE DE LA SALLE SA		
en naza tun denten ar du 1900 paga kanga kuma mana sa du ulu a-mana sa mana bahaka it a mina 40 kilos	attille met Professioners and American Service and American Service and American Service Am						
					all Arbeignes (ACA Announce) and as a Calland Arbeignes (CA) (Calland Materials and Arbeignes (CA)	att finde der skrige zu de aut vijskelendelige finde geleigt finde finde finde finde finde finde finde finde f	
Signature of Head of Department or delegate			Date				
Print Name	nacionale de procesa de contrato de la propriementa en como na se anoma de la como de		Designation			(90)	
ACTIONS	Captured/Executed		Checked &		& signed off		
1. Employee notified of decision							
2. Decision captured on PERSAL							
3. Salary overpayment recovered, if applicable	THE PROPERTY OF THE PROPERTY O						