ANNEXURE A

APPLICATION FORM: TEMPORARY INCAPACITY LEAVE
SHORT PERIODS

IMPORTANT

1 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.

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. 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.

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 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.

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 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 APPLICANT							
Surname				First names			
Date of Birth				ID No			
PERSAL NO				Gender	Female	Male	
Shift Worker	Yes		No	Contract Employee	Yes	No	
Address during Absence							
Contact numbers	@ home		@ work		Cell phone		
Email Address							
Period of Absence	Start date			End date			

CHECK LIST OF MEDICAL EVIDENCE OR ADDITIONAL MOTIVATION TO BE ATTACHED	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 sbmit 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 Health Risk Manager appointed by the Employer 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 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 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.

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 C: DECISION ON APPLICATION

1. COMMENTS BY SUPERVISOR/MANAGER
Attach a loose page if necessary

SIGNATURE OF SUPERVISOR/ MANAGER

DATE

2. 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 *Policy and Procedure on Incapacity Leave and Ill-health Retirement (PILIR)*
Remarks or conditions:

SIGNATURE OF HOD/DESIGNEE

DATE

PART D: 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 work?	Yes		No		Uncertain	

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

3.3 **Please provide 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 & no)		**Fax no** (Code & no)	
E-mail address			
ALTERNATIVE CONTACT PERSON			
Contact person in department		**Designation**	
Tel no (Code & no)		**Fax no** (Code & 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 either been 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 or delegate		Date	
Print Name		Tel no (Code & No)	

PART F: FINAL DECISION BY THE HEAD OF DEPARTMENT

Temporary incapacity leave requested in Part A is 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		