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AIDS HELPLINE: 0800-0123-22 Prevention is the cure

CONTENTS

No.		Page No.	Gazette No.
	GOVERNMENT NOTICE		
	Labour, Department of		
	Government Notice		
648	Compensation for Occupational Injuries and Diseases Act (130/1993): Forms to be used in the reporting of claims for Work-related Upper Limb Disorders	3	26384

GOVERNMENT NOTICE

DEPARTMENT OF LABOUR**No. 648****21 May 2004****THE COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES
ACT, (ACT No 130 OF 1993), AS AMENDED**

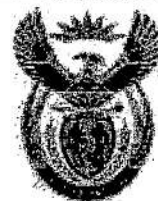
In terms of section 6A of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993, as amended), I, Sibongile Winifred Magojo, Compensation Commissioner, hereby prescribe the following forms to be used in the reporting of claims for Work-related Upper Limb Disorders:

W.Cl. 301 First Medical Report in respect of Work-related Upper Limb Disorders

W.Cl. 302 Progress / Final Medical Report in respect of Work-related Upper Limb Disorders

**SW MAGOJO****COMPENSATION COMMISSIONER**

FIRST MEDICAL REPORT IN RESPECT OF A WORK-RELATED UPPER LIMB DISORDER (WRULD)

Claim number: 

Compensation for Occupational Injuries and Diseases Act, 1993 (Act number 130 of 1993)

[Section 6A(b) – Commissioner's rules, forms and particulars – Annexure 25]

**This form must be completed by a medical practitioner and sent to
the Compensation Commissioner, PO Box 955, Pretoria, 0001**

Employee: Surname: Identity number:

First names:

Address: Code:

Employer:

Address: Code:

1. Date symptoms first started: 2. Date of first consultation: 3. Date of specific diagnosis:

4. Specific diagnosis of this upper limb disorder:

5. The symptoms the employee experiences (tick the appropriate box/es):

- | | | |
|---|--|--|
| <input type="checkbox"/> Burning sensation | <input type="checkbox"/> Fatiguability | <input type="checkbox"/> Loss of grip strength |
| <input type="checkbox"/> Loss of normal sensation | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Paraesthesia (tingling) | <input type="checkbox"/> Sensation of cold | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Stiffness and cramps | | |

Describe:

6. The clinical signs found on examination (tick the appropriate box/es):

- | | |
|--|---|
| <input type="checkbox"/> Crepitus (crackling sound in subcutaneous tissue) | <input type="checkbox"/> Muscle spasm |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Reduction of range movement |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Tender trigger points in muscles |
| <input type="checkbox"/> Tenderness | |

Describe:

7. Is the employee left or right handed? ☐ Right ☐ Left Sex: ☐ Male ☐ Female Age: years

8. Height of employee: cm Weight of employee: kg Body mass index:

9. Which special medical investigation/s and/or job analysis / ergonomic assessments were done to prove the diagnosis and/or what other potential causes of the above-mentioned upper limb disorder have been investigated / eliminated? (Where applicable, please attach these reports.)

10. Does the employee suffer from any other diseases? (If so, please specify)

11. Describe the nature of any previous injuries sustained and/or abnormalities to the employee's upper limb/s?

*Encircle correct answer

Please turn over and complete reverse side.

12. Appraise the job or summarise the job analysis / ergonomic assessment of the job which has allegedly caused the disorder, in terms of these risk factors (Where applicable, attach photos, diagrams and/or job analysis / ergonomic assessment):

Risk factor	Percentage of working day	Briefly describe the job task where this risk factor occurs and quantify in terms of repetitions / duration / strength required / range of movement, etc.
Repetitive movements		
Movements requiring force		
Movements at the extremes of reach		
Static muscle loading		
Awkward sustained postures		
Contact stress		
Vibration		
Low temperatures		

13. How long has the employee been doing this job? years months

14. Explain how this alleged occupational disease progressed over a period of time in terms of function (i.e. signs and symptoms with relation to job tasks) [E.g. wrist pain started after 8 hours of sewing 6 months ago (no clinical signs). Currently increased pain after 30 minutes of sewing with pain keeping her out of sleep. Positive Phalen and Tinel tests and reduction in grip strength.]

15. Have any of the employee's colleagues, performing a similar job, complained of similar symptoms? If yes, explain.

16. Explain how this condition was managed before this specific diagnosis was made in terms of:

a) The Person Medically (e.g. medication, surgery, etc.):

Functionally (e.g. rehabilitation, etc.):

b) The Job Task adaptation (e.g. job rotation, shorter hours, etc.):

Equipment adaptation (e.g. extended handle on tool used, etc.):

17. Is the employee currently fit to work? If yes, is he/she performing his/her* or ?
If the employee is performing alternate/adapted work, is this position* or ?

I certify that I have by examination of the employee, satisfied myself of the above-mentioned facts.

Signature

(Medical Practitioner):

Name (printed):

Qualifications:

Practice number:

Registered address with HPCSA:

Code:

Date (Important):

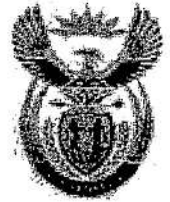
IMPORTANT:

- All questions must be answered in full (use extra paper if necessary).
- Full motivation of diagnosis will prevent unnecessary correspondence and delays in adjudication of claim.
- The form must be forwarded to the employer within 14 days after the specific diagnosis was made. The employer must forward this report to the Compensation Commissioner.
- Please submit medical accounts separately. Attach a copy of this report to your account.
- It is advisable to consult the Compensation Commissioner's "Guidelines for Managing Work-Related Upper Limb Disorders" before reporting this condition.
- The employer must submit a copy of this report to the Provincial Executive Manager of the Department of Labour (Occupational Health and Safety Act) or the Regional Principal Inspector of Mines (Mine Health and Safety Act).
- The employer must submit a Progress Medical Report (W.Cl. 302) and a Resumption Report (W.Cl. 6) on a monthly basis to the Compensation Commissioner or Mutual Association or employer individually liable, as the case may be, until the employee's condition has become stabilised, when a Final Medical Report (W.Cl. 302) should be submitted.

*Encircle correct answer

W.Cl. 301

PROGRESS / FINAL* MEDICAL REPORT IN RESPECT OF A WORK-RELATED UPPER LIMB DISORDER (WRULD)

Claim number: 

Compensation for Occupational Injuries and Diseases Act, 1993 (Act number 130 of 1993)

[Section 6A(b) – Commissioner's rules, forms and particulars – Annexure 26]

This form must be completed by a medical practitioner and sent to
the Compensation Commissioner, PO Box 955, Pretoria, 0001

Employee: Surname: Identity number:

First names:

Address: Code:

Employer:

Address: Code:

Specific diagnosis: Date of specific diagnosis:

A. CURRENT CLINICAL CONDITION OF EMPLOYEE (Complete this section)

1. Since the previous Medical Report, is there an improvement in the severity of the symptoms the employee is experiencing and clinical signs found on examination? ** Explain. ☐ YES ☐ NO
2. Describe how the employee's condition has been managed since the previous report (mention dates of procedures, tests, etc.) in terms of the following:
 - a. Medically (e.g. medication, surgery, etc.)
 - b. Functionally (e.g. rehabilitation, etc.)

B. COMPLETE THE FOLLOWING SECTION ONLY IF THE EMPLOYEE IS CURRENTLY NOT WORKING DUE TO THIS CONDITION

3. Is the employee still in the employment of the above-mentioned employee? If yes, answer the following questions: ☐ YES ☐ NO
 - a. Since when is the employee not working because of this occupational disease? (Date)
 - b. When do you expect the employee to return to work? (Date)
 - c. Will the employee be returning to his/her usual job? ** ☐ YES ☐ NO
 - i. If yes, are there any task adaptations? * ☐ YES ☐ NO If yes, please explain (e.g. job rotation, shorter hours)
 - ii. If yes, are there any equipment adaptations? ** ☐ YES ☐ NO If yes, please explain (e.g. extended handle on tool used)
 - d. Is the employee returning to an alternate position? * ☐ YES ☐ NO If yes, is this position ☐ TEMPORARY or ☐ PERMANENT **
 - e. What arrangements have been made with the employer regarding the employee's re-introduction to work (e.g. work hardening, shorter hours, etc.)?

C. COMPLETE THE FOLLOWING SECTION ONLY IF THE EMPLOYEE IS CURRENTLY AT WORK:

4. Was the employee off work for more than 2 days due to this condition? ** ☐ YES ☐ NO
 If yes, the period the employee was not at work, was from (inclusive) to (Dates)

5. Has the employee returned to his/her usual job? ** ☐ YES ☐ NO

a. If yes, are there any task adaptations? * ☐ YES ☐ NO If yes, please explain (e.g. job rotation, shorter hours)

b. If yes, are there any equipment adaptations? ** ☐ YES ☐ NO If yes, please explain (e.g. extended handle on tool used)

6. Has the employee returned to an alternate position? ** ☐ YES ☐ NO If yes, is this position ** ☐ TEMPORARY or ☐ PERMANENT ?

If yes, then analyse the job that the employee has returned to in terms of the risk factors below:

Risk factor	Percentage of working day	Briefly describe the job task where this risk factor occurs and quantify in terms of repetitions / duration / strength required / range of movement, etc.
Repetitive movements		
Movements requiring force		
Movements at the extremes of reach		
Static muscle loading		
Awkward sustained postures		
Contact stress		
Vibration		
Low temperatures		

7. Did the employee receive a planned re-introduction when returning to work? ** ☐ YES ☐ NO

8. Are you aware of any adaptation to the workplace that are planned / implemented by the employer to prevent other employees from developing WRULDs? ** ☐ YES ☐ NO

9. Are you aware of an occupational health programme that is in place to assess the health risks causing WRULDs and to do adequate medical surveillance and health education? ** ☐ YES ☐ NO

10. Are you aware of a company policy to address WRULDs? ** ☐ YES ☐ NO

D. PROGNOSIS (Complete this section)

11. Has the employee's condition been optimally managed since the previous Medical Report in terms of medical treatment and actions taken in response to the functional capacity and job analysis / ergonomics assessments? If no, please explain. ☐ YES ☐ NO

12. a. Has the employee's condition become stabilised (i.e. reasonable medical intervention will not improve the employee's condition)? ☐ YES ☐ NO

b. If yes, has there been any permanent anatomical defect and/or Impairment of functions as a result of this occupational disease? If yes, describe this in detail and substantiate by special reports where necessary. ☐ YES ☐ NO

I certify that I have by examination of the employee satisfied myself of the above-mentioned facts.

Signature Registered address with HPCSA:
 (Medical Practitioner):
 Name (printed):
 Qualifications: Code:
 Practice number: Date (Important):

IMPORTANT:

- All questions must be answered in full (use extra paper if necessary).
- The form must be forwarded to the employer who will send it to the Compensation Commissioner.
- Please submit medical accounts separately. Attach a copy of this report to your account.
- It is advisable to consult the Compensation Commissioner's "Guidelines for Managing Work-Related Upper Limb Disorders" before completing this report.
- The employer must submit a copy of this report to the Provincial Executive Manager of the Department of Labour (Occupational Health and Safety Act) or the Regional Principal Inspector of Mines (Mine Health and Safety Act).
- A Progress Medical Report (W.C.I. 302) and a Resumption Report (W.C.I. 6) must be submitted by the employer on a monthly basis to the Compensation Commissioner or Mutual Association or employer (individually liable, as the case may be, until the employee's condition has become stabilised, when a Final Medical Report (W.C.I. 302) should be submitted).

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