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

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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):

- ☐ Burning sensation
- ☐ Fatiguability
- ☐ Loss of grip strength
- ☐ Loss of normal sensation
- ☐ Muscle weakness
- ☐ Pain
- ☐ Paraesthesia (tingling)
- ☐ Sensation of cold
- ☐ Swelling
- ☐ Stiffness and cramps

Describe:

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

- ☐ Crepitus (crackling sound in subcutaneous tissue)
- ☐ Muscle spasm
- ☐ Muscle weakness
- ☐ Reduction of range movement
- ☐ Swelling
- ☐ Tender trigger points in muscles
- ☐ 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.

W.CI. 301

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. Yes / No

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?* Yes / No If yes, is he/she performing his/her* Usual work or Alternate/Adapted work ?

If the employee is performing alternate/adapted work, is this position* Temporary or Permanent ?

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.)?

*Delete which is not applicable **Encircle the correct answer
Please turn over and complete reverse side.

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 (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).
- 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.CI. 302) and a Resumption Report (W.CI. 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.CI. 302) should be submitted.

***Encircle correct answer*

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