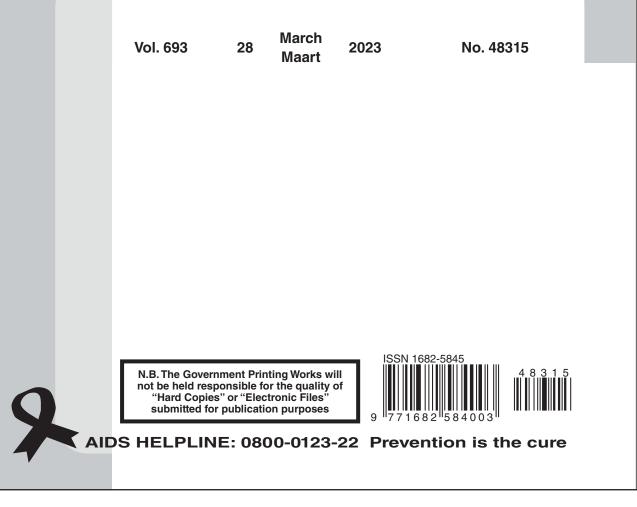


#### Gazette C overn men 2 R 0 D I C Δ



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#### Contents

No.

1716

Gazette Page No. No.

#### GENERAL NOTICES • ALGEMENE KENNISGEWINGS

Employment and Labour, Department of / Indiensneming en Arbeid, Departement van

3

## GENERAL NOTICES • ALGEMENE KENNISGEWINGS

#### DEPARTMENT OF EMPLOYMENT AND LABOUR

#### **GENERAL NOTICE 1716 OF 2023**



employment & labour Department: Employment and Labour REPUBLIC OF SOUTH AFRICA

Compensation Fund, Delta Heights Building 167 Thabo Sehume Street, Pretoria 0001 Tel: 0860 105 350 | Email address: <u>cfcallCentre@labour.gov.za</u> <u>www.labour.gov.za</u>

### **Corrections to Notice number: 48308**

#### **Chiropractor Annexures**

The 2 pages were to be inserted at the end of the Notice/Gazette, after page 21.



# CHIROPRACTOR ANNEXURES 2023

| STAATSKOERANT, 28 MAART 2023 |  |
|------------------------------|--|
|                              |  |

Claim Number: -----

## **REHABILITATION PROGRESS REPORT**

#### COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASE ACT

| ames    | and Surname of Employee   |
|---------|---|
| dentity | v Number Address  |
|         | Postal Code   |
| lame    | of Employer   |
| ddres   | SS  |
|         | Postal Code   |
| Date of | f Accident  |
| 1.      | Date of first treatment Provider who provided first treatment                                   |
| 2.      | Initial clinical presentation and functional status   |
| 3.      | Name of referring medical practitioner  |
|         | Date of referral  |
| 4.      | Describe patient's current symptoms and functional status                                       |
|         |   |
| 5.      | Are there any complicating factors that may prolong rehabilitation or delay recovery (specify)? |
| 6.      | Overall goal of treatment:  |
| 7.      | Number of sessions already delivered Progress achieved  |

Claim Number: -----

- 8. Number of sessions required\_\_\_\_\_ Treatment plan for proposed treatment sessions\_\_\_\_\_
- 9. From what date has the employee been fit for his/her normal work?\_
- 10. Is the employee fully rehabilitated / has the employee obtained the highest level of function?
- 11. If so, describe in detail any present permanent anatomical defect and / or impairment of function as a result of the accident ( R.O.M, if any must be indicated in degrees at each specific joint)\_\_\_\_\_

| I certify that I have by examination, satisfied myself that the injury(ies) are as a |                  |  |  |  |
|--|------------------|--|--|--|
| result of the accident.  |                  |  |  |  |
| Signature of rehabilitation service provider   |                  |  |  |  |
| Name( Printed)   | Date( Important) |  |  |  |
| Address  |                  |  |  |  |
| Practice number  |                  |  |  |  |

NB: Rehabilitation progress reports must be submitted on a monthly basis and attached to the submitted accounts.

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