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

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## GENERAL NOTICES • ALGEMENE KENNISGEWINGS

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### 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: [cfcallCentre@labour.gov.za](mailto:cfcallCentre@labour.gov.za) [www.labour.gov.za](http://www.labour.gov.za)

### 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**

Claim Number: \_\_\_\_\_

**REHABILITATION PROGRESS REPORT****COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASE ACT**

Names and Surname of Employee \_\_\_\_\_

Identity Number \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_ Postal Code \_\_\_\_\_

Name of Employer \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Postal Code \_\_\_\_\_

Date of 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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