THE FEDERATED EMPLOYERS MUTUAL ASSURANCE COMPANY (RF) (PTY) LTD

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PROGRESS MEDICAL REPORT

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 AS AMENDED

EMPLOYEE DETAILS

Claim Number:	**Date of Accident:**	**Staff Number:**
Name of Employer:		
Name of Employee:		

1.	(a) Is the condition healing satisfactorily? (b) If not, state briefly the hindering or complicating factors	
2.	Will further treatment- (a) by yourself (b) by a specialist result in further improvement of employee's condition/ state treatment plan	
3.	Have you had a consultation in respect of this case since last report? If so, when and with whom? **(N.B. – Copies of Consultant's report must be attached.)**	Date: Consultant: Results:
4.	(a) From what date has employee been fit for his normal work or (b) On what date is he likely to be fit for his normal work?	
5.	Have any X-rays been taken since the last report? If so, state (N.B. – Copies of Radiologists' report must be attached.)	Date: By whom: Results:
6.	Have any operative (including manipulative) procedures been undertaken since the previous report? If so, state	Date: By whom: Local or General Anaesthetic _____ If General: Duration_____Minute Brief Report
7.	Have any anti-sera or vaccines or plaster of Paris bandages been used in the course of treatment since the previous report? If so, state dates and quantities	
8.	Have you ordered physiotherapy/Occupational therapy since the previous report? Estimated duration	

DECLARATION

I hereby declare that the information furnished in this report is true and correct according to my knowledge.

Initials Surname:	Practice No
E-mail:	Tel:
Signature:	Date: