Claim Number ____________

FIRST MEDICAL REPORT IN RESPECT OF POST TRAUMATIC STRESS DISORDER

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993
(Act No. 130 of 1993)

[Section 6A(b) – Commissioner's Rules, Forms and Particulars – Annexure 21]

Names and Surnames of Employee			
Identity Number		Address	
		Postal Code	
Name of Employer			
Address			
		Postal Code	

1. Date of accident ____________ 2. Date of your first consultation ____________
3. How did the alleged accident happen? ____________
4. Full Psychiatric Diagnosis (Five Axis)
   Axis 1 ____________
   Axis 2 ____________
   Axis 3 ____________
   Axis 4 ____________
   Axis 5 ____________
5. Describe briefly any ***pre-existing*** defect of disease ____________
6. Special investigations: Date ____________ By whom ____________
   Brief Description ____________
   (Attach report if available)
7. Treatment up to present: Date ____________ By whom ____________
   Brief Description ____________
8. (a) Consultation Yes / No ______ With whom ____________ Date ____________
9. (a) Is the employee unfit for work? Yes / No ______
   (b) Possible date fit for: Light duty ____________ Normal Duty ____________

I certify that I have by examination, satisfied myself that the condition of the employee is the result of the accident as described above.

Signature of General Medical Practitioner / Psychiatrist/ Psychologist ____________

Name (Printed) ____________ Date (important) ____________

Address ____________

____________ Postal Code ____________ Practice number ____________

NB This report must be handed to the injured employee or sent to the employer within 14 days from the date of the first consultation.

W. Cl. 303