ANNEXURE A

APPLICATION FORM: TEMPORARY INCAPACITY LEAVE

SHORT PERIODS

INSTRUCTIONS ON COMPLETION OF THE APPLICATION FORM

1 This application form must be completed in respect of an incapacity leave period of **less than 30 working days.**

2 This form comprises six parts, i.e. Parts A to F and Appendix 1. The employee must complete Parts A and B or C. The Supervisor must complete Part D, the HR Department must complete Part E and the Head of Department or his or her delegate must complete Part F. Appendix 1 must be completed by the Medical Practitioner at the time of consulting and the issuing of the medical certificate.

3 Please ensure that this form is duly completed, signed and accompanied by all the required supporting documents, as missing or omitted information will delay finalisation of the application. You are reminded that the submission of a medical certificate with each application is mandatory. Please also refer to the *Determination and Directive on Leave of Absence in the Public Service* for the requirements in respect of medical certificates.

4 This application is subject to an investigation in terms of the *Determination and Directive on Leave of Absence in the Public Service,* read together with the *Policy and Procedure on Incapacity Leave and Ill-health Retirement.* In the light hereof, the Employer shall grant temporary incapacity leave **conditionally** for a maximum period of 29 working days with full pay subject to the outcome of the said investigation. Please note that if this application is declined based upon the outcome of the investigation, the period of temporary incapacity leave shall be converted to annual leave or granted as unpaid leave.

5 Cognisance must also be taken of the fact that the employee is responsible for proving to the Employer's satisfaction that s/he is too ill/injured to be at work. ***The employee is, in keeping with the principles contained in item 10 of Schedule 8 of the Labour Relations Act, 1995, therefore afforded the opportunity to submit additional medical evidence related to the medical condition of the employee together with his/her application. This may include but is not limited to medical reports from a specialist, blood test results, x-ray results, scan results, etc. or any additional motivation/evidence which the employee deems relevant and which supports and states his/her case, and which the employer should take into account in contemplating the application for incapacity leave.***

6 This application form and supporting documentation is classified as 'Confidential' in terms of the Minimum Information Security Standards.

7 Checklist on documents required for all applications:

7.1 Medical certificate (Compulsory) (Appendix 1 to Annexure A must at all times accompany the medical certificate)

7.2 Medical report(s) (Recommended)

7.3 Blood tests, x-ray results, scan results, etc. (Recommended)

7.4 Additional written motivation (Recommended)

7.5 A Shift Roster must be attached to the application if an employee is a shift worker.

8 An employee may include the recommended supporting documents in a sealed envelope addressed for the attention of the Health Risk Manager. This sealed envelope must be attached to this application form.

9 If an employee is unable to complete the form he/she may seek assistance from his/her supervisor, a colleague, the Human Resources component, a relative or friend to assist him or her.

10 It is important to note that failure to grant consent may have a detrimental effect on the outcome of the application because it will be assessed based on the available information at the employer's disposal.

FOR OFFICIAL USE	
Employee Name	
Persal no	
Unique case number	
Incapacity Leave Period	

PART A: DETAILS OF EMPLOYEE (All fields in this part are mandatory and must be completed)

1. PERSONAL PARTICULARS									
Surname				First names					
Title				Persal No					
Date of Birth				ID No					
Gender:		Female				Male			
Nature of appointment:	Permanent Full time		Permanent Part Time		Temporary Full Time		Temporary Part Time		
Shift Worker		Yes				No			
Address during Absence				Email Address					
Contact numbers	home		work		mobile				
Medical Aid:				Medical Aid Plan/Option:					
Date of first appointment in Public Service				Date of appointment to present post (if different):					
Salary Level		Annual basic salary/TCE Package			Last day at work				
Period of Absence	Start date		End date		Number of incapacity leave days applied for				

2. DETAILS OF YOUR ILLNESS/INJURY
2.1. Describe in your own words the illness/injury (not injury on duty) that has given rise to this application specifically the symptoms/impairments that disable you and prevent you from working.
2.2. How does your illness, injury (not injury on duty), or condition limit your ability to work/function? (Please elaborate which elements of your job you are prevented from performing)

2.3. Detail exactly what medication you are taking for your condition. List all, i.e. chronic medication, new medication recently added / given, as well as the dosage for each.
2.4. Please indicate whether you suffer from any side effects from the medication and the nature thereof.

3. DECLARATION*			
I hereby declare and warrant that the information provided is factual, true and correct, and that no material information has been withheld or any relevant circumstances omitted. Any falsification of information in this regard may form grounds for disciplinary action. I understand that the burden of proof of my illness/injury rests with me and that I am afforded the opportunity to submit additional medical evidence and motivation to this effect with this application. I know and understand that if I fail to do so, it would be of my own choice and that the omission of such information may impact upon the decision regarding my application.			
SIGNATURE OF EMPLOYEE:		Date:	
In the event that this application is signed by anyone other than the employee , i.e. a Third Party, please provide the following information:			
Full name and surname of signing third party:			
Telephone no of third party		Cell No of third party	
Reason for signing on employee's behalf			
Relationship of signing third party to Employee (e.g. spouse, colleague, union representative, friend etc.)			
SIGNATURE OF THIRD PARTY if Employee is unable to sign for any reason, e.g. employee is in hospital, unconscious etc.		Date:	

PART B: EMPLOYEE CONSENT FORM

Instructions

1 **Please see paragraph 10 of the instructions on page 1.**

2 **If you choose not to grant consent do not complete this part but proceed to part C of this application form.**

Authority

I_____, ID No _____
PERSAL No_____ an employee of _____ (hereinafter referred to as "the Employer") hereby authorise any medical practitioner, hospital, institution, clinic, health care provider or any other relevant person that may hold any medical records relating to me and /or any treatment or advice provided to furnish and release to the Employer and Health Risk Manager appointed by the Employer any and all details and information, specifically including confidential information, relating to any illness, injury or condition including, but not limited to, all clinical records, laboratory results (including blood and other tests), x-rays, records of all prescribed medications and treatments, progress reports and summaries, correspondence between my medical practitioner and any other person who has provided treatment or where I have been a patient or from whom I have received any medical treatment of any nature whatsoever.

I know and understand that by providing this authority I am curtailing my right to privacy and acknowledge and agree that this is necessary and essential for the Employer and the Health Risk Manager to consider, inter alia, the provision of incapacity leave and/or ill health retirement benefits.

This authority is limited to such information as may reasonably be required by the Employer for the purpose of considering and evaluating an application for incapacity leave and/or ill health retirement benefits and for no other purpose without my prior written consent.

I hereby authorise the Employer to disclose and make available to the Health Risk Manager any and all information referred to above as well as any other information that may be in the Employer's possession, including previous applications for incapacity leave and /or ill health retirement benefits, medical reports, job descriptions and specifications and related records. I further authorise the Health Risk Manager to disclose and make available any of the aforegoing information in its possession to the Employer.

I confirm that a photocopy of this authority shall be as effective and valid as the original.

Consent to Undergo Medical Examination

I acknowledge that for the Employer to consider and evaluate any application for incapacity leave and/or ill health benefits, I may be required to undergo medical and/or psychological evaluation and other tests including, but not limited to, blood tests, for the purpose of determining the nature, extent and duration of any incapacity or illness suffered by me.

I further acknowledge that the Employer, or its Health Risk Manager, may make appointments on my behalf to attend any required medical or other required evaluation as they may determine on reasonable prior notice to me and that, subject to the provisions set out below, the costs of any such evaluation shall be the responsibility of the Health Risk Manager. I understand that if I fail to honour the latter appointment, the Employer shall recover the fruitless expenditure for the missed appointment from me.

I undertake to present myself for any appointment timeously and with any and all required documentation and information as advised by the Employer or its representatives and agree that in the event that I neglect or fail to attend any appointment without reasonable prior notice to the employer and without acceptable justification, any and all costs or charges that may be incurred consequent upon my failure to attend will be payable in full by me on demand by the Employer.

Indemnity

I hereby indemnify the Employer and its Health Risk Manager against any claim whatsoever, which may be made against them as a result of, or arising from the furnishing of any information as provided for herein unless such claim or furnishing of my information provided herein arose from or is as a result of any wilful or negligent act of the Employer, its employees and its Health Risk Manager and its agents.

Signed at_____ on this the _____day of _____ 20___.

SIGNATURE/MARK OF EMPLOYEE:		**Date:**	
In the event that this Consent Form is signed by anyone other than the employee , i.e. a Third Party, please provide the following information:			
Full Name and Surname of signing third party:			
Telephone no of third party		Cell No of third party	
Reason for signing on employee's behalf			
Relationship of signing third party to Employee (e.g. spouse, colleague, Union representative, friend etc.)			
SIGNATURE OF THIRD PARTY if employee is unable to sign for any reason. (E.g. employee is in hospital, Unconscious etc.)		Date:	

Signature of witness		**Date**	
Full Name & Surname :			
Tel No. :			
Cell No. :			

PART C: EMPLOYEE REFUSAL OF CONSENT FORM

Instructions

1 **Please see paragraph 10 of the instructions on page 1.**
2 **Do not complete this part if you completed Part B.**

Authority

I_____, ID No _____;

PERSAL No_____ an employee of the _____ (hereinafter referred to as "the Employer") hereby refuse to give consent –

a) for the release to the Employer and Health Risk Manager appointed by the Employer of any and all details and information, specifically including confidential information, relating to any illness, injury or condition including, without limitation, all clinical records, laboratory results (including blood and other tests), x-rays, records of all prescribed medication and treatments, progress reports and summaries, correspondence between my medical practitioner and any other person who has provided treatment or where I have been a patient or from whom I have received any medical treatment of any nature whatsoever.

b) To be subjected to any further medical examination that the Employer or its Health Risk Manager may require.

I know and understand that by not providing consent I acknowledge and agree that the Employer and the Health Risk Manager will only consider available information to assess my incapacity leave and/or ill health retirement application.

Indemnity

I hereby indemnify the Employer and its Health Risk Manager against any claim whatsoever, which may be made against them as a result of, or arising from my refusal to give consent.

Signed at_____ on this the _____day of _____ 20___.

SIGNATURE/MARK OF EMPLOYEE::		**Date:**	
In the event that this Consent Form is signed by anyone but the applicant him or herself, i.e. a Third Party, please provide the following information:			
Full Name and Surname of signing third party:			
Telephone no of third party		Cell No of third party	
Reason for signing on employee's behalf			
Relationship of signing third party to Employee (e.g. spouse, colleague, Union representative, friend etc.)			
SIGNATURE OF THIRD PARTY if Employee / Applicant is unable to sign for any reason. (E.g. Applicant is in hospital, Unconscious etc.)		Date:	

Signature of witness		**Date**	
Full Name & Surname :			
Tel No. :			
Cell No. :			

PART D: MOTIVATION OF SUPERVISOR/MANAGER (All fields in this part are mandatory and must be completed)

1 Describe your observations including the impact the employee's illness has had on the employee and his/her ability to work. Attach a separate page as an annexure if necessary

2 JOB DETAILS OF THE EMPLOYEE

Job Title:		Does the employee have staff reporting to him/her?	Yes		No	
Prescribed daily hours of work or if a shift worker, average daily hours of work						
Does this employee perform night shifts	Yes	No				

3 EMPLOYEE'S CURRENT JOB DEMANDS

PLEASE SPECIFY THE PERCENTAGE (%) TIME SPENT ON:
(Total percentage to equal 100%)

NATURE OF TASK:	PERCENTAGE	NATURE OF TASK:	PERCENTAGE	NATURE OF TASK:	PERCENTAGE
Managerial		Administrative		Clerical	
Supervisory		Light Manual		Heavy Manual	
Machine Operator		Travel		Driver	
Other (Specify)					

4 RECOMMENDATION OF SUPERVISOR OR MANAGER:

Application supported		Application not supported	
If not supported, please provide reasons for not supporting application			

Full Name & Surname of Supervisor / Manager:	
Designation	
Tel Number:	
Cell Number:	
SIGNATURE OF SUPERVISOR/ MANAGER	
Date:	

PART E: REPORT TO THE HEALTH RISK MANAGER COMPLETED BY THE HUMAN RESOURCES DIVISION

IMPORTANT NOTES						
The following documentation must be attached:						
Medical certificate with Appendix 1 (supplied by employee)						
Medical reports, (if supplied by employee)						
Blood tests, x-ray results, scan results, etc. (If supplied by employee)						
Additional written motivation (If supplied by employee)						
PERSAL printout of all leave records of the previous & current leave cycles (PERSAL Function #4.5.1 Option 5)						
Copies of all sick leave forms and medical certificates for the current and previous leave cycle						
Sealed envelope marked for the attention of the Health Risk Manager (If supplied by employee)						
A Shift Roster if an employee is a shift worker						
Contact details of Human Resource Manager or Delegate(as per written delegation) :						
Name				Surname		
Designation:						
Department:		Province		National		
Department address:						
Contact number:	Work		Cellphone		Fax Number	
Email address:						
Signature:						
Date:						
Contact details of alternative person in Human Resource						
Name and Surname of contact person in department		Designation				
Contact number:	Work		Cellphone		Fax Number	
E-mail address						

DECLARATION			
I hereby declare that the information provided is to the best of my knowledge true and correct and that no material information has either been withheld or omitted.			
Print Name & Surname			
Signature of Head of Department or delegate (as per written delegations)		Date	

PART F: FINAL DECISION BY THE HEAD OF DEPARTMENT (All Fields are mandatory and must be completed)

Temporary incapacity leave requested	Approved	Partially Approved	Not Approved
COMMENTS/CONDITIONS/INSTRUCTIONS:			
Print Name			
Signature of Head of Department or delegate as per written delegations		Date	

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ACTIONS	CAPTURED/EXECUTED		CHECKED & SIGNED OFF	
Employee notified of decision	Name & Surname:		Name & Surname:	
	Date actioned		Date actioned	
Decision captured on PERSAL	Name & Surname:		Name & Surname:	
	Date actioned		Date actioned	
Salary overpayment recovered or Leave without pay implemented, (if applicable)	Name & Surname:		Name & Surname:	
	Date actioned		Date actioned	
Referred to EHW (if applicable)	Name & Surname:		Name & Surname:	
	Date actioned		Date actioned	
Referred to Labour Relations (if applicable)	Name & Surname:		Name & Surname:	
	Date actioned		Date actioned	