ANNEXURE B

APPLICATION FORM TEMPORARY INCAPACITY LEAVE

LONG PERIOD

INSTRUCTIONS ON COMPLETION OF THE APPLICATION FORM

1 This application form must be completed in respect of incapacity leave periods of **30 working days or more.**

2 This form comprises seven parts, i.e. Parts A to G. The employee must complete Parts A and B or C. The employee's attending Medical Practitioner must complete Part D. (It is the employee's responsibility to have the said part completed by the Medical Practitioner.) The Supervisor must complete Part E, the HR Department must complete Part F and the Head of Department or his or her delegate must complete Part G.

3 Please ensure that this form is duly completed, signed and accompanied by all the required supporting documents, because 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 30 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 either annual leave or be unpaid leave.

5 Cognisance must also be taken of the fact that the employee is responsible to 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)
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 only based on the available information at the employer's disposal.

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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								
Date of birth		ID no						
Persal 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								
Contact numbers	home		work		cell phone			
Email address								
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. WORK HISTORY			
2.1 Please provide a history of all previous jobs in or outside of the Public Service in the last five (5) years			
From	To	Employer	Work designation

2.2 Describe the duties and functions of your current job:

2.3 Details of education and training :

2.4 Please give details of your highest level of education as well as training (academic, technical, in service).

Year qualified	Institution	Qualification

2.5 Considering your training and experience, for what alternative jobs do you consider yourself qualified or skilled within or outside your current department?

3. DETAILS OF YOUR ILLNESS/INJURY

3.1 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

3.2 In your opinion, will you recover from current ill-health to the extent of returning to work?	Yes		No		Uncertain	

If no or uncertain, list and detail the work duties you are unable to perform.

3.3 Which of the following are you unable to do due to your illness/injury? Kindly tick below:

PHYSICAL				**MENTAL**		**ACTIVITIES OF DAILY LIVING**			
Lifting		Walking		Understanding		Eating		Sport	
Stair climbing		Sitting		Short term memory		Dressing		Use of public transport	
Bending		Kneeling		Concentration		Bathing		Recreational activities	
Standing		Talking		Following instructions		Domestic chores,			
Seeing		Hearing		Calculation		Shopping			
Using hands				Long term memory		Driving			

3.4 Please give the details of hospitalisation in the past 5 years.

Name of hospital	Reason for admission	Date admitted	Date discharged	Relevant Medical Practitioner's name	(Specialisation	Detail of Treatment /

3.5 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.

3.6 Please indicate if you suffer from any side effects from the medication and the nature thereof.

3.7	Have you consulted any of the following practitioners, including but not limited to: physiotherapist, occupational therapist, psychologist, audiologist, speech therapist, dietician during the period applied for?	Yes		No	

If yes, kindly provide details.

4 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	home		work		cell phone	
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	home		work		cell phone	
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	home		work		cell phone
Reason for signing on employee's behalf					
Relationship of signing third party to Employee (e.g. spouse, colleague, Union representative, friend					
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 D: MEDICAL REPORT (To be completed by the attending Medical Practitioner)

Dear Medical Practitioner,

We would appreciate your co-operation in providing the information requested in this form.

This employee, your patient, has exhausted all of the normal sick leave of 36 working days to which he/she is legally entitled for the entire three-year sick leave cycle, and is now requesting additional fully paid additional sick leave. In the context of this consultation, should you decide to recommend the granting of sick leave he/she will be required to apply for Temporary Incapacity Leave for the period in question.

Importantly, such fully paid Temporary Incapacity leave is not a right in terms of the Basic Conditions of Employment Act, (BCEA) but is essentially an employee privilege granted entirely at the discretion of the Head of Department. Consequently, more detailed objective medical information is required, in addition to the standard Medical Certificate.

Failure to provide detailed and adequate medical data in this Medical Report may result in there being insufficient information on which to make an informed decision and as such the employee may well be granted unpaid leave for the duration of his / her absence.

Thank you sincerely for taking the time to complete this report. Your assistance is greatly appreciated.

1. EMPLOYEE DETAILS	
Title	
Surname	
First name	
Persal number	
Id number	
Date of birth	
How long have you been the patient's treating Medical Practitioner?	
On which date did you first consult with the patient?	
On which date did you last consult with the patient?	

2. EMPLOYEE'S MEDICAL DETAILS
2.1. DIAGNOSIS
2.1.1. What is the nature of the illness/injury from which the patient is suffering? Please indicate the diagnosis (DSM/ICD), if applicable.
2.1.2. What were the presenting symptoms and when did they first appear?
2.1.3. Please detail any co-morbid conditions that will impact on the employee's recovery and incapacity.
2.2. IMPAIRMENT
2.2.1. Describe fully the nature and extent of the physical impairment which resulted in the patient's inability to perform his/her normal duties
2.2.2. Describe fully the nature and extent of the cognitive and /or psychological impairment which resulted in the patient's inability to perform his/her normal duties. (Including MMSE/MoCA if applicable).
2.2.3. In the case of a psychiatric condition, please indicate the GAF at the beginning of treatment and the GAF at review consultations.

2.3. MEDICAL HISTORY

2.3.1. Please detail the onset and history of the illness and/ or injury, including the presenting symptoms.

2.3.2. Please provide details of ***ALL*** consultations with the patient over at least the past six (6) months in the table below:

Date of consultation	Complaint	Treatment	Response

2.3.3. Please provide details of other medical practitioners' referrals or of hospital admissions over at least the past 3 years.

Name of hospital	Reason for admission	Date admitted	Date discharged	Relevant Medical Practitioner's name	Speciality	Treatment / surgery

2.4. INVESTIGATIONS

2.4.1. Please detail the objective findings, such as blood tests, x-ray reports, ECG, Echocardiography findings, histology results, etc. PLEASE INCLUDE COPIES OF ALL AVAILABLE REPORTS.

2.4.2. In the case of cardiac conditions, please indicate the most recent ventricular ejection fraction and the grading of dyspnoea according to the NYHA.

2.4.3. In the case of pulmonary disorders, kindly include the most recent lung function test results.

2.4.4. In the case of spinal (neck and back) conditions, kindly include latest radiology report.
2.4.5. In your opinion should the patient undergo further investigations? Please comment.
2.5. TREATMENT
2.5.1. Please provide details of present treatment, i.e. medication (product name, strength, dosage and duration), rehabilitation, counselling, etc. and how successful they have been.
2.5.2. Please comment on the patient's compliance with and response to all treatment initiated.
2.5.3. Please detail any complications or side effects of treatment experienced by the patient.
2.5.4. In your opinion could further treatment (e.g. pharmacological / surgical and/or rehabilitation) be beneficial to the patient.

2.6. PROGNOSIS				
2.6.1. What, in your opinion, is the estimated long term prognosis for the patient's condition?				
2.6.2. In your opinion, is the present incapacity temporary or permanent? In the case of temporary incapacity, please indicate an estimated time period and what is the patient's occupational prognosis (if applicable)?				
2.6.3. What is the estimated degree of recovery? Kindly tick below:				
No recovery	Partial recovery		Full recovery	
2.7. WORK ABILITY				
2.7.1. Do the patient's work duties and / or environment and /or labour related issues affect the illness or injury or work ability?	Yes		No	
If yes, please provide details:				
2.7.2. Please comment on the general mobility of the patient and indicate if assistive devices are required.				
2.7.3. In your opinion, if the patient is not able to perform his/her duties, what adapted or alternate duties are possible?				

2.8. GENERAL
2.8.1. Please add any general comments in respect of this patient's state of health that will assist in assessing the employee's application.

3. MEDICAL PRACTITIONER'S DETAILS:			
Surname:		Initials:	
Practice No:		HPCSA Registration No:	
Email Address:		Fax No:	
Address:			
Telephone Number:		Cell phone number:	

4. DECLARATION
I hereby declare and warrant that the information given above is factual, true and correct and that no material information has been withheld nor any relevant circumstances omitted.

Signed at _____on this _____ Day of _____ 20___

_____

SIGNATURE OF MEDICAL PRACTITIONER

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

1. Describe your observations and the impact the employee's illness 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/Average daily hours of work							
Nature of Appointment	Full-time		Fulltime: Shift work		Part-time		Contract	
Does this employee perform night shifts	Yes				No		
If the employee perform night shifts on a regular basis has s/he requested to undergo a medical examination in terms of section 17 (3) (b) of the BCEA, 1997 as amended? (If a report has been issued and health related issues have been identified please attach a copy of the report to this application.)		Yes			No		

3. EMPLOYEES' CURRENT JOB DEMANDS					
PLEASE SPECIFY THE PERCENTAGE (%) TIME SPENT IN: **(Total percentage to equal 100%)**					
TASK	PERCENTAGE:	TASK	PERCENTAGE:	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 phone Number:	
Date:			
SIGNATURE OF SUPERVISOR/ MANAGER			

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

IMPORTANT NOTES

1. **The following documentation must be attached:**
2. **Medical certificate (SUPPLIED BY EMPLOYEE)**
3. **Medical reports (If supplied by employee)**
4. **Blood tests, x-ray results, scan results, etc. (If supplied by employee)**
5. **Additional written motivation (If supplied by employee)**
6. **PERSAL printout of all leave records of the previous & current leave cycles (PERSAL Function #4.5.11 Option 5)**
7. **Copies of all sick leave forms and medical certificates for the current and previous leave cycle**
8. **Sealed envelope marked for the attention of the Health Risk Manager (If supplied by employee)**
9. **A Shift Roster if an employee is a shift worker**
10. **Medical report issued in terms of section 17 (3)(b) of the BCEA, 1997 as amended (if applicable)**

1. CONTACT DETAILS OF HR MANAGER OR DELEGATE(as per written delegation) :					
Name		Surname			
Designation:					
Department:		Province		National	
Department address:					
Contact number (Code & no):	Work		Alternative		
	Cell phone		Fax no		
Email address:					
Signature:		Date:			

2. CONTACT DETAILS OF ALTERNATIVE PERSON IN HR						
Name and Surname of contact person in department			Designation			
Contact number (Code & no):	Work		Alternative		Fax no	
E-mail address						
3. 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 G: 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	