Claim Number: _______________

labour
Department:
Labour
REPUBLIC OF SOUTH AFRICA

REQUEST FOR REOPENING OF A CLAIM

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

(Act No. 130 of 1993)

PLEASE WRITE LEGIBLY

Name of Employee			
Identity Number		Address	
		Postal Code	
Name of Employer			
Address			
		Postal Code	

1.	Date of Accident/ Onset of Disease			2.	Date of Consultation	
3.	Has Permanent Disablement been awarded by COIDA?	YES	NO		PERCENTAGE if known	
4.	State the specific diagnosis and the present condition of the employee					
5.	List the special investigations performed to confirm (4) **(Attach report/s)**					
6.	Describe the relationship of the present condition to the original injury/ disease sustained (If the only relationship is persistence of symptoms, provide dates of doctors' consultations, diagnoses, treatment administered and attach sick leave records)					

7	Detailed treatment plan, with date of hospital admission and proposed procedure(s), name of hospital and **estimated costs and the codes to be used**. (Please attach a separate page with this information, if the space provided is not enough.)
8.	How will the proposed treatment reduce the disablement the employee is suffering from?
9.	Other health team members who will be involved during the procedure / treatment.

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 Medical Practitioner		Practice number	
Name (Printed)		Date (important)	
Dr's telephone number	e-mail address	Fax number	Cell
Address			
Signature of the employee		Date(important)	
Employee's contact number			

DOCTORS NAME STAMP……………………………………………………………