



ANNEXURE A

**APPLICATION FORM: TEMPORARY INCAPACITY LEAVE  
SHORT PERIODS**

**IMPORTANT**

- 1 This application form must be completed in respect of an incapacity leave period of **less than 30 working days**.
- 2 This form comprises of six parts, i.e. Parts A to F. The employee must complete Parts A and B. Parts C to F are for official use.
- 3 Please ensure that this form is duly completed, signed and accompanied of all the required supporting documents, since lacking information will delay finalisation of the application. Refer also the *Determination on Leave of Absence* for the requirements with regard to medical certificates.
- 4 This application is subject to an investigation in terms of the *Determination on Leave of Absence*, read 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 the outcome of the said investigation. Note must be taken that if this application is declined based upon the outcome of the investigation that the period of temporary incapacity leave shall be converted to either annual leave or unpaid
- 5 Cognisance must be taken of the fact that the employee is responsible to proof to the Employer's satisfaction that s/he is too ill/injured to be absent from work. The employee is therefore and in keeping with the principles contained in item 10 of Schedule 8 of the Labour Relations Act, 1995, afforded the opportunity to submit together with his/her application additional medical evidence related to the medical condition of the employee, such as a medical reports from a specialist, blood tests results, x-ray results or scan results, etc. or any additional motivation which s/he deems relevant supporting motivation/evidence stating 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 in terms of the Minimum Information security Standards as 'Confidential'.

For Health Risk Manager's use	
Employee Name	
PERSAL NO	
Unique case number	
Incapacity Leave Period	



**APPLICATION FORM TEMPORARY INCAPACITY LEAVE: SHORT PERIOD**

**PART A: EMPLOYEE'S APPLICATION FOR TEMPORARY INCAPACITY LEAVE**

PARTICULARS OF APPLICATION																		
Surname							First names											
Date of Birth	y	y	y	y	m	m	d	d	ID No									
PERSAL NO									Gender	Female	Please tick	Male	Please tick					
Shift Worker	Yes		No		Casual Employee				Yes		No							
Address during Absence																		
Contact numbers	@ home				@ work				Cell phone									
	Code & tel number				Code & tel number													
Period of Absence	Start date	y	y	y	y	m	m	d	d	End date	y	y	y	y	m	m	d	d

Check list of medical proof/evidence to be attached	Tick
Medical certificate (compulsory)	
Medical report(s) (optional)	
Blood tests, x-ray results, scan results, etc. (optional)	
Additional written motivation (optional)	

<b>DECLARATION</b>	<p><i>I hereby declare and warrant that the information given is factual, true and correct, and that no material information has been neither withheld nor any relevant circumstances omitted. Any falsification of information in this regard may form ground 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 application. I do understand that if I fail to do so that it would be of my own choice and that the omission of such information my impact upon the decision regarding my application.</i></p>		
Employee signature or of person completing form if applicant is unable to do so		Date	



**PART B: EMPLOYEE CONSENT FORM**

**Authority**

I \_\_\_\_\_, ID No \_\_\_\_\_ PERSAL No \_\_\_\_\_ an employee of \_\_\_\_\_ (hereafter 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, without limitation, 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 Employers 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 foregoing 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 and/or ill health benefits, I may be required to undergo medical and/or psychological evaluation and other tests including, without limiting the generality of the afore-going, 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 provision set out below, the costs of any such evaluation shall be the responsibility of the Health Risk Manager. I understand that that if I fail to honour the latter appointment, that the Employer shall recover the fruitless expenditure attached to my non-keeping of the appointment shall be recovered 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 with acceptable justification, any and all costs or charges that may be incurred consequent on 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 of whatever nature, which may be made against them as a result of, or arising from the furnishing of any information as provided for herein.

Signed at \_\_\_\_\_ on this the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_.

Employee’s signature/ mark or of person completing form if applicant is unable to do so

Signature of witness 1		Date	
Full Name & Surname :			
Tel No. :		Code	
Cell No. :			

Signature of witness 2		Date	
Full Name & Surname:			
Tel No. :		Code	
Cell No. :			

**REFUSAL TO GIVE CONSENT**

I \_\_\_\_\_, ID No \_\_\_\_\_ PERSAL No \_\_\_\_\_ an employee of \_\_\_\_\_ (hereafter referred to as “the Employer”) refuse to give consent as required above.

Employee’s signature/ mark or of person completing form if applicant is unable to do so



**PART C: DECISION ON APPLICATION**

**APPROVAL BY THE HEAD OF DEPARTMENT**

Incapacity leave **conditionally** granted pending the outcome of the investigation in terms of the *Directive on Leave of Absence in the Public Service* and the *Management Policy and Procedure on Incapacity Leave and Ill-health Retirement for Public Service Employees*

**Remarks or conditions:**

\_\_\_\_\_  
**SIGNATURE OF HOD/DESIGNEE**

\_\_\_\_\_  
**DATE**



**PART D: THE DEPARTMENT'S REPORT TO THE HEALTH RISK MANAGER**

<b>1. NAME OF DEPARTMENT</b>			
Western Cape Provincial Administration	Please tick	National Department	Please tick
Northern Cape Provincial Administration	Please tick	Mpumalanga Provincial Administration	Please tick
Eastern Cape Provincial Administration	Please tick	Limpopo Provincial Administration	Please tick
Free State Provincial Administration	Please tick	North West Provincial Administration	Please tick
Gauteng Provincial Administration	Please tick	KwaZulu-Natal Provincial Administration	Please tick

<b>2. PARTICULARS ON THE EMPLOYEE</b>					
Date joined department/ Public Service				Job title	
Full-time/Part-time				Annual basic salary	
Current physical workplace (city/town)				Level of Education/ training	
On normal sick leave	Yes	Please tick ✓	No	Please tick	Last day at work
On incapacity leave sick leave	Yes	Please tick ✓	No	Please tick	

<b>3. ADDITIONAL INFORMATION ON THE EMPLOYEE</b>		
3.1 Cause of incapacity	Please tick	Brief description of illness/injury
▪ Ill-health	Please tick	
▪ Accident/Injury on duty	Please tick	
▪ Accident/Injury off-duty	Please tick	



<ul style="list-style-type: none"> <li>▪ Violence off-duty</li> </ul>	Please tick					
<ul style="list-style-type: none"> <li>▪ Other (please specify)</li> </ul>	Please tick					
<b>3.2 Is it expected that the employee will recover to the extent of returning to work?</b>	Yes	Please tick	No	Please tick	Uncertain	Please tick

If no or uncertain, please elaborate:


**3.3 The employee's sick leave record for the current and previous sick leave cycle or attach a PERSAL printout from function #4.5.1 option 5 provided that the PERSAL records are up to date. If necessary, the said information could be supplied on a separate sheet. In such an event the sheet must be attached to this form.**

From	To	Number of working days	Reason

<b>4. CHECK LIST OF DOCUMENTATION TO BE ATTACHED</b>	Please tick
<ul style="list-style-type: none"> <li>▪ Medical certificate (SUPPLIED BY EMPLOYEE)</li> </ul>	Please tick
<ul style="list-style-type: none"> <li>▪ Medical reports (If supplied by employee)</li> </ul>	Please tick
<ul style="list-style-type: none"> <li>▪ Blood tests, x-ray results, scan results, etc. (If supplied by employee)</li> </ul>	Please tick



<ul style="list-style-type: none"> <li>▪ Additional written motivation (If supplied by employee)</li> </ul>	Please tick
<ul style="list-style-type: none"> <li>▪ PERSAL printout of sick leave records of the previous &amp; current sick leave cycles (PERSAL Function #4.5.1 Option 5)</li> </ul>	Please tick

<b>5. CONTACT DETAILS OF DEPARTMENT (Please provide details of two contact persons)</b>
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Physical address of Department			
CONTACT PERSON IN DEPARTMENT		Designation	
Tel no	Code & tel. number	Fax no	Code & fax number
E-mail address			

<b>ALTERNATIVE CONTACT PERSON</b>
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Contact person in department		Designation	
Tel no	Code & tel. number	Fax no	Code & fax number
E-mail address			

<b>DECLARATION</b>	<i>I hereby declare and warrant that the information given is to my knowledge factual, true and correct and that no material information has been either withheld or any relevant circumstances omitted.</i>		
Signature of Head of Department or delegate		Date	
Print Name		Designation	



**PART E: SUMMARY OF HEALTH RISK MANAGER'S RECOMMENDATION**

*(The full report and recommendation is attached)*

<b>Periods concerned</b>	<b>Recommended Yes/No</b>	<b>Motivation</b>	
1.			
2			
3			
<b>Signature of HRM</b>		<b>Date</b>	
<b>Print Name</b>		<b>Tel no</b>	<b>Code &amp; tel. number</b>



**PART F: FINAL DECISION BY THE HEAD OF DEPARTMENT**

Temporary incapacity leave requested in Part A is approved / not approved.

Comments/conditions/instructions

<b>Signature of Head of Department or delegate</b>		<b>Date</b>	
<b>Print Name</b>		<b>Designation</b>	

<b>ACTIONS</b>	<b>Captured/Executed</b>	<b>Checked &amp; signed off</b>
<b>1.Employee notified of decision</b>		
<b>2. Decision captured on PERSAL</b>		
<b>3.Salary overpayment recovered, if applicable</b>		