



2nd Floor Lakeside Office Park, 263 West Street, Centurion, P.O. Box 11962, Centurion, 0046 Tel: (012) 683-1400, Fax: (012) 663-4345/9157

**NOTIFICATION AND CONSENT FORM: Injury on Duty (IOD) and Case Management**

*Supervisor/manager: complete and sign page 1. Employee: complete and sign page 2.*

*Please fax the completed form to PHS on 012-663 4345.*

*Enquiries: Contact the Case Management Department on telephone 012-683 1436/1434*

**Identifying details**

Employee's name: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home address: \_\_\_\_\_

Telephone number: (\_\_\_\_\_) \_\_\_\_\_

**Occupational information**

Salary number: \_\_\_\_\_ Region: \_\_\_\_\_

Business unit: \_\_\_\_\_ Occupation: \_\_\_\_\_

Brief description of Occupation: \_\_\_\_\_

Job requirements (physical/ mental): \_\_\_\_\_

**Medical information**

Medical problems – injury or illness: \_\_\_\_\_

Date of injury/ onset of illness: \_\_\_\_\_

Sick leave taken from \_\_\_\_\_ to \_\_\_\_\_

Returned to normal duty:  or Returned to alternative duty:

**Contact detail at work**

Name and signature of HR administrator: \_\_\_\_\_ Date: \_\_\_\_\_

Tel: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Name of supervisor \_\_\_\_\_ Tel: \_\_\_\_\_

## Employee Consent Form

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Salary No: \_\_\_\_\_

Contact detail of treating doctor/s and other health professionals:

<i>Name</i>	<i>Profession</i>	<i>Telephone &amp; Fax numbers</i>

I hereby give consent to Pro-Active Health Solutions (Pty) Ltd to obtain all medical information relevant to this application from the doctors, therapists and other health care providers who have examined and/or treated me.

**This medical information will be used for the sole purpose of evaluating my health status and thereby my ability to perform work duties.**

Signed:

Employee: \_\_\_\_\_ Witness: \_\_\_\_\_

Place: \_\_\_\_\_ Date: \_\_\_\_\_