FINAL MEDICAL REPORT

DETAILS OF INJURED EMPLOYEE			
Name of Employee:			
Date of Birth: / /	Occupation:		Cell No:
Name of Employer:		Date of Accident/Onset of Disease: / /	
RMA Claim No:		Industry No:	

DETAILS OF INJURY				
Mechanism of injury:				
Clinical description of original injury/injuries or disease:				
Is the present disablement solely attributable to the accident? Yes		No		
If yes, are there any additional contributory causes?				

Please email to: rmascannings@randmutual.co.za
For queries contact us on: 0860 222 132

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Has the clinical condition stabilised and not likely to improve? Yes		No						
ICD10 codes								

Impairment findings:
Date on which the employee is due to return to work: / /

DECLARATION	
I declare that after my examination of the above patient, I am satisfied that the injury is work-related and consistent with the injury sustained.	
Surname:	Initials:
Email:	Tel:
Practice No:	Cell No:
Address:	
	Code:
Signature:	Date: / /
IMPORTANT: Please submit all medical reports, radiographs, specialist tests or diagnostic procedures. These are essential if an employee is referred to an assessment clinic.	

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FINAL MEDICAL EVALUATION REPORT	
Describe in detail the impairment that has resulted from the injury. This will enable RMA's assessor or the Compensation Commissioner to make a fair assessment of the disablement. Please use the hand, foot, eye or other support forms as required. Where necessary, please submit photographs.	
Detailed clinical description:	
Name of doctor:	
Email:	
Tel:	Cell No:
Signature:	Date of evaluation: / /

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