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| Labour Coporate ID Text Con | Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**REQUEST FOR REOPENING OF A CLAIM - GENERAL****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. |
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| 5. | List the special investigations performed to confirm (4) **(Attach report/s)** |  |
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| 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) |
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| 7. | Detailed treatment plan, with date of hospital admission and proposed procedure(s), name of hospital and estimated cost with codes to be used. (Please attach a separate page with this information, if the space provided is not enough) : |
| ICD 10-Code: |
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| Name of Pharmacy and Practice Number: |
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| List of medication and/or Consumables including Nappi Codes: |
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| 8. | How will the proposed treatment reduce the disablement the employee is suffering from? : |
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| 9. | Other health team members who will be involved during the procedure / treatment : : |
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**I certify that I have by examination, satisfied myself that the condition of the employee is the result of the accident as described above.**

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| Signature of Medical Practitioner  |  | Practice number |  |
| Name of Medical Practitioner |  | Date |  |
| Dr’s telephone number | Email address | Fax number | Cell |
| Address |  |
| Signature of the employee |  | Date(important) |  |
| Employee’s contact number |  |

**DOCTORS NAME STAMP** :