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 six parts, i.e. Parts A to F. The employee must complete Parts A and B. Parts C to F are for official use only.

3 Please ensure that this form is duly completed, signed and accompanied by all the required supporting documents, as missing or omitted information will delay finalisation of the application. Please also refer to the *Determination on Leave of Absence* for the requirements in respect of medical certificates.

4 This application is subject to an investigation in terms of the *Determination on Leave of Absence*, read together 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 29 working days with full pay subject to the outcome of the said investigation. Please note that if this application is declined based upon the outcome of the investigation, the period of temporary incapacity leave shall be converted to either annual leave or be unpaid leave.

5 Cognisance must also be taken of the fact that the employee is responsible to prove to the Employer's satisfaction that s/he is too ill/injured to be at 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 medical reports from a specialist, blood test results, x-ray results, scan results, etc. or any additional motivation/evidence which the employee deems relevant and which supports and states 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 as 'Confidential' in terms of the Minimum Information Security Standards.

FOR HEALTH RISK MANAGER'S USE	
Employee Name	
PERSAL NO	
Unique case number	
Incapacity Leave Period	

APPLICATON FORM TEMPORARY INCAPACITY LEAVE: SHORT PERIOD

PART A: EMPLOYEE'S APPLICATION FOR TEMPORARY INCAPACITY LEAVE

PARTICULARS OF APPLICATION																									
Surname									**First names**																
Date of Birth									**ID No**																
PERSAL NO									**Gender**	**Female**						**Male**									
Shift Worker	**Yes**			**No**					**Casual Employee**				**Yes**				**No**								
Address during Absence																									
Contact numbers	**@ home**								**@ work**								**Cell phone**								
Period of Absence	**Start date**												**End date**												

CHECK LIST OF MEDICAL EVIDENCE OR ADDITIONAL MOTIVATION TO BE ATTACHED	Tick
Medical certificate (compulsory)	
Medical report(s)	
Blood tests, x-ray results, scan results, etc.	
Additional written motivation	

DECLARATION:	***I hereby declare and warrant that the information given is factual, true and correct, and that no material information has been withheld or any relevant circumstances omitted. Any falsification of information in this regard may form grounds 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 sbmit additional medical evidence and motivation to this effect with this application. I do understand that if I fail to do so that it would be of my own choice and that the ommission of such information may impact upon the decision regarding my application.***		
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 aforegoing 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 expendituremy non-keeping of theappointment 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 the _____

refuse to give consent as required above.

Employee's signature or mark 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

1. NAME OF DEPARTMENT	(Please tick the appropriate box)		
Western Cape Provincial Administration		National Department	
Northern Cape Provincial Administration		Mpumalanga Provincial Administration	
Eastern Cape Provincial Administration		Limpopo Provincial Administration	
Free State Provincial Administration		North West Provincial Administration	
Gauteng Provincial Administration		KwaZulu-Natal Provincial Administration	

2. PARTICULARS ON THE EMPLOYEE						
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		No		Last day at work	
On incapacity leave	Yes		No			

3. ADDITIONAL INFORMATION ON THE EMPLOYEE		
3.1 Cause of incapacity	Please tick	Brief description of illness/injury
▪ Ill-health		
▪ Accident/Injury on duty		
▪ Accident/Injury off-duty		
▪ Violence off-duty		
▪ Other (please specify)		

3.2 **Is it expected that the employee will recover to the extent of returning to work?**	**Yes**		**No**		**Uncertain**	

If **no** or **uncertain**, please elaborate:

3.3 **Please provide 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

4. CHECK LIST OF DOCUMENTATION TO BE ATTACHED	Please tick
▪ **Medical certificate (SUPPLIED BY EMPLOYEE)**	
▪ **Medical reports (If supplied by employee)**	
▪ **Blood tests, x-ray results, scan results, etc. (If supplied by employee)**	
▪ **Additional written motivation (If supplied by employee)**	
▪ **PERSAL printout of sick leave records of the previous & current sick leave cycles (PERSAL Function #4.5.1 Option 5)**	

5. CONTACT DETAILS OF DEPARTMENT (Please provide details of two contact persons)			
Physical address of Department			
CONTACT PERSON IN DEPARTMENT		**Designation**	
Tel no (Code & no)		**Fax no** (Code & no)	
E-mail address			
ALTERNATIVE CONTACT PERSON			
Contact person in department		**Designation**	
Tel no (Code & no)		**Fax no** (Code & no)	
E-mail address			

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

PART E: SUMMARY OF HEALTH RISK MANAGERS RECOMMENDATION

(The full report and recommendation is attached)

Periods concerned	**Recommended Yes/No**	**Motivation**
1.		
2		
3		

Signature of HRM		**Date**	
Print Name		**Tel no (Code & No)**	

PART F: FINAL DECISION BY THE HEAD OF DEPARTMENT

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

COMMENTS/CONDITIONS/INSTRUCTIONS:

Signature of Head of Department or delegate		**Date**	
Print Name		**Designation**	

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