EMPLOYEES COMPENSATION ACT, 1941
FIRST MEDICAL REPORT AND ACCOUNT

E.CL. 4

CLAIM NO: ……

Surname of Employee: ……

First Name (s): ……

Address: ……

Name of Employer: ……

Address: ……

1. Date of Accident: …… Date of Consultation: ……

2. How did the alleged accident happen? ……

……

3. Full clinical description of injury (ies): ……

……

……

4. Describe briefly any pre-existing defect or disease — Dates: ……

……

……

5. X-Rays Date:…… By whom: ……
(Attach report if available)

6. Surgical Operations or Reduction: Date:…… By whom: ……

Brief description: ……

……

……

7. Anaesthetics General: …… Duration: …… Local: …… By whom:……

8. (a) Consultation: Yes/No: …… With Whom: …… Date: ……

(b) Is physiotherapy ordered? Yes/No: …… Physiotherapist:…… ……

9. (a) Is employee unfit for his/her work? Yes/No: ……

(b) Possible date fit for: …… Light duty: …… Normal duty: ……

**** Account l.r.o. first consultation and/or procedure (s)**

Your Account No.:…… PR. No.: .:……

Description of Service	Place and Date of Treatment or Visits	Item of Tariff	N$	C

I certify that I have by examination, satisfied myself that the injury (ies)/condition of the employee is the result of the accident as described above.

Date (important) ……

……
Signature of Medical Practitioner

Name (Printed): ……

Registered Address: ……

……

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N.B. This report must be handed to the injured employee or sent to his/her employer without delay.

**Please submit separate accounts for further service.

PRINTECH c.c. 98/24268