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EMPLOYEES COMPENSATION ACT, 1941
FIRST MEDICAL REPORT AND ACCOUNT

CLAIM No.: .....

Surname of Employee: .....

First Name(s).....

Address: .....

Name of Employer: .....

Address: .....

1. Date of Accident: ..... Date of your first consultation: .....

2. How did the alleged accident happen? .....

.....

3. Full clinical description of injury(ies) (precision is essential, and technical terms may be used).
(See pages 3 and 5 of Handbook:) .....

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4. In your opinion, is the employee's condition due to the accident described in item 2 above? .....

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5. Describe briefly any pre-existing defect(s) or disease – Dates: .....

6. X – Rays Date: .....By whom: .....
(Attach report if available)

7. Surgical Procedures or Reduction: Date: .....By whom: .....

Brief description: .....

.....

8. Anaesthetics: Local: .....General: .....Duration: .....By whom: .....

9. (a) Consultation: Yes/No: ..... With whom: ..... Date: .....

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

10. Is employee unfit for duty? Yes/ No: .....Possible date fit for: Light duty: .....Normal Duty: .....

**Account i.r.o. first consultation or procedure(s)

Your Account No.: .....Practice No.: .....

Description of service	Place and dates of treatment or visits	Item of tariff	N$	c

I certify that I have by examination, satisfied myself that the injury(ies) 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 services.