

	ANNEXURE 3 – MEDICAL CERTIFICATE	Rev. Date:	2019/07
		Document Number:	S8 A3
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		Revision Number:	1
Contractor:			

OCCUPATIONAL HEALTH AND SAFETY ACT, 85 OF 1993 - Construction Regulations GNR.84 of 7 February 2014

"medical certificate of fitness" means a certificate contemplated in regulation 7(1)(8);

(8) A contractor must ensure that all his or her employees have a valid medical certificate of fitness specific to the construction work to be performed and issued by an occupational health practitioner in the form of Annexure 3.

Section 1 – Contractor to complete:

Name of Employee: ID number: Employment number:

Occupation	Possible Exposures (insert possible exposures)					Job Specific Requirements					Protective Equipment				

Section 2 Declaration by the Medical Examiner: (Please sign in the applicable box. If the box is not applicable, please indicate it with a N/A on the signature line in the first column and the word CANCELLED across the words in the second column)

A) Signature: _____	A) I certify that I have, by examination and testing, using the above criteria specified by the employer, satisfied myself that the abovementioned employee is fit to perform the duties as described by the employer in the matrix above and find this person: 1) Not mentally disordered or physically defective in any way to perform the duties as described by the employer in the matrix above, 2) Not suffering from any disease, trachoma or infections or contagious condition that will prevent this person to perform the duties as described by the employer in the matrix above, 3) Generally in a good state of health.
B) Signature: _____	B) I certify that I have, by examination and testing, using the above criteria specified by the employer, did not satisfied myself that the abovementioned employee is fit to perform the duties as described by the employer in the matrix above and observed the following defects: _____ _____ _____
C) Signature: _____	C) I certify that I have, by examination and testing, using the above criteria specified by the employer, satisfied myself that the abovementioned employee is able to perform less strenuous duties in the work situation.

NB! Occupational Medical Practitioner/Occupational Health Nursing Practitioner Checklist (Compulsory: Please attach the following):

1	I have attached a copy of the examination and testing done by myself,	Yes	Compulsory
2	I have attached a copy of the audiometric results	Yes	Compulsory
3	Working at heights where taken into consideration during the medical exam:	Yes	No
3.1	If Not why not:		

Occupational Medical Practitioner/Occupational Health Nursing Practitioner: (Please print name):

.....

Time: Expiry date: (One year from date of examination)

Address:

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Practice Number: Date: Signature:

Occupational Medical
 Practitioner/Occupational Health
 Nursing Practitioner STAMP: