



Caring | Compassionate | Compensation

FIRST MEDICAL REPORT									
DETAILS OF INJURED EMPLOYEE									
Employee Name:									
Date of Birth:			Occupation:				Cell No:		
Employer Name:									
Date of Accident/Onset of Disease: / /						Date of Consultation:			
RMA Claim No:				Industry No/Company No:					
DETAILS OF INJURY									
Mechanism of injury:									
Detailed clinical description of injuries/disease:									
Are the injuries consistent with the mechanism of the injury?						No			
Yes									
ICD10 Codes:									
Briefly describe any pre-existing condition or disease (if any):									

Please email to: rmascannings@randmutual.co.za

For queries contact us on: 0860 222 132



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Treatment:			X-rays		Surgery		Referral
Conservative							
Please give detail:							
If the patient is unfit for work, please specify dates: From / / To / /							
Or, please state preliminary estimate of days absent from work:							
DECLARATION							
I declare that after my examination of the above patient, I am satisfied that the injury is work-related and consistent with the injury sustained.							
Surname:						Initials:	
Email:						Tel:	
Practice No:						Cell No:	
Address:							
						Code:	
Signature:						Date:	

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