Claim Number:	
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## REQUEST FOR REOPENING OF A CLAIM COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (Act No. 130 of 1993)

## PLEASE WRITE LEGIBLY

		PLEASE WRITE LEGIBLY							
Na	me of Employee								
Ide	ntity Number			Addres	s				
								Postal Cod	e
Na	me of Employer								
Ad	dress								
								Postal Cod	e
1.	Date of Accident/ Onset of Dise	ease				2.	Date of Co	onsultation	
3.	Has Permanent Disablement be	en awarded by	COIDA?	YES	NO	Pl	ERCENTA	GE if known	
4.	State the specific diagnosis and	the present cor	ndition of the	he empl	oyee				
5.	List the special investigations p report/s)	performed to confirm (4) (Attach							
6.	Describe the relationship of the present condition to the original injury/ disease sustained  (If the only relationship is persistence of symptoms, provide dates of doctors' consultations, diagnoses, treatment administered and attach sick leave records)								
									,

Detailed treatment plan, with date of hospital admission and proposed procedure(s), name of hospital and <b>estimated costs and the codes to be used</b> . (Please attach a separate page with this information, if the space provided is not enough.)								
Hospital name and practice no:								
All proposed Procedure codes:								
Date of admission and possible no. of days for admission:								
•	v							
8. How will the proposed treatment re	8. How will the proposed treatment reduce the disablement the employee is suffering from?							
9. Other health team members who will be involved during the procedure / treatment.								
I certify that I have by examination, satisfied myself that the condition of the employee is the result of the accident as described above.								
Signature of Medical Practitioner		Practice number						
Name (Printed)		Date (important)						
Dr's telephone number	e-mail address	Fax number	Cell					
Address								
Signature of the employee Date(important)								
Employee's contact number (IMPORTANT)								
	DOCTOR'S STAMP							