QualiCare

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Return to work documentation during COVID-19 pandemic:

- **Employee's confidential declaration (Page1)**
- **Doctor's examination (Page 2)**
- **Employee's Application / special concession and comorbidities for COVID-19 (Page3)**
- **Confirmatory report by doctor (Page 4)**

See page 4 on instructions for completion of these forms

Declaration by employee

Name and surname of employee:____

Known as:____ Date of birth:_____/______/______

ID Number:____

Work Function / designation:____

Known chronic disease/s:____

History of Symptoms or signs of COVID disease within the past 14 days:

- Do you have or did you have a dry cough?______________________________________
- Do you have or did you have an upper respiratory infection?______________________
- Do you have or did you have diarrhea?____
- Do you have or did you have a sore throat?_____________________________________
- Do you have or did you have bodily aches and/or extreme tiredness?________________
- Do you have or did you have a severe headache?_________________________________
- Do you have or did you have difficulty breathing?________________________________
- Do you have or did you have loss of, or difference in, your ability to taste or smell?__________
- Have you been in contact with a positive COVID-19 case?__________________________
- Have you been in or travelled to an infected area within the Western Cape Province?________
- If so, to which area? ____
- Have you left the Western Cape province?_______________________________________

I hereby certify that all of the above information is true, and that I have not withheld any of the above information from the doctor completing this form______________________________

Signature of the employee: ____

Witness: Name and signature of examining doctor:_________________________________

Practice stamp: Date:____/_____/_____

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Doctor's Examination

Full name and surname of employee:______________________________

ID number:______________________________

Temperature______________________________

Ear nose and throat______________________________

Pulse______________________________

Blood Pressure______________________________

Chest examination______________________________

Cardiovascular examination______________________________

Smoking history______________________________

HGT______________________________

Examining Doctor's Recommendation

- **Fit to return to work Y / N**
- **Unfit for work from / / 20___ until and including / /20___** **(Attach separate Sick Certificate)**
- **Employee's Application for Concession on grounds of Comorbidities for COVID-19, attached Y / N**

  The application for comorbidities for COVID-19 concession, on page 3, must be signed by the employee (worker).

  This application will require a medical opinion to be completed (see page 4) and signed by the examining doctor.

Name and signature of employee______________________________

Name, signature, and degrees of examining Doctor:______________________________

____

____

MP Number:______________________________

Date: ____/____/____ Practice stamp

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Employee's application form for concession due to reported comorbidities for COVID-19

This form is a declaration by the employee not by the doctor

Attention: ______________________________ (Employer)

I, ____(Full Name and Surname of employee applying for concession), hereby apply for a Concession regarding working during the Covid-19 pandemic, due to one or more of the Comorbidities for COVID-19 below.

The employee must personally tick the appropriate RISK FACTOR/S and the appropriate DETAIL/S column, below:

RISK FACTOR	Tick only correct risk factor/s	DETAIL	Tick only correct detail/s
Age		I am above 50 years of age	
Cardiovascular Disease		Moderate / Severe Hypertension	
		Congestive cardiac failure or other serious cardiovascular disease	
		Cerebrovascular disease, including stroke and transient ischaemic attack	
Respiratory Disease		Pulmonary Tuberculosis – untreated or in early treatment	
		Moderate to severe asthma	
		Chronic Obstructive Pulmonary Disease (COPD)	
		Other severe chronic lung pathology, including emphysema, cystic fibrosis and/ or bronchiectasis	
Kidney Disease		Chronic Kidney Disease	
Pregnancy		28 or more weeks pregnant	
Diabetes Mellitus		Poorly controlled Type 1 & 2 Diabetes	
Immunosuppression		Cancer undergoing active treatment	
		Human Immunodeficiency Virus with advanced immunosuppression	
		Chronic immunosuppressant use	
		Organ Transplant	
Primary Immunodeficiencies		Diagnosed Primary Immunodeficiency	
Metabolic Syndrome		Severe obesity	

I have my detailed plan on how my duties will be performed from home (to be completed and attached by the employee)	**Y / N**	If no when will it be available?
I attach a medical opinion ** by a licensed medical practitioner (see page 4)	**Y / N**	

Signature of employee (worker):______________________________Date: ____/_____/_____

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Medical opinion on the application for concession due to comorbidities for COVID-19, as deposed by the employee.

Full Name and ID Number of the employee applying for work the concession:

____

Declaration by the doctor

I hereby declare that:

- I confirm the comorbidities for COVID-19, stated in the above employee's application form.
- I do not confirm the comorbidities for COVID-19, stated in the above employee's application form.

(Delete the inapplicable)

Name, Surname, Signature and Degrees of doctor:______________________________

MP Number:____

Practice stamp

Date __/__/__

Instruction for completion of above forms:

- This application form comprises 4 pages.
- Page 1 comprises of a declaration by the employee (worker) the doctor only witnesses the employee's signature.
- Page 2, the "examining doctor's recommendation", will result in either "fit to return to work" (which require no further comment from the doctor), OR "unfit for work from… to…." This will require a separate sick certificate to be attached, signed by the examining doctor.
- The "employee's application form concession", is made by the employee, not by the doctor. It may be completed by the doctor on behalf of the employee but must be signed by employee (worker).
- No item on this form has been altered or amended.
- The completed application comprising of all 4 pages, should be photocopied, and placed in the worker's folder and the original given to the worker: Code 0133 applies to complete this form.

Disclaimer:

*This document is based upon the **"Guidance on vulnerable employees and work place accommodation in relation to COVID-19 (V4: 25 May 2020)",** which is an interim guide from the DOH that may be updated by the DOH at any time in the future. Qualicare will, to the best of its ability release updated forms for "Return to work" during the COVID-19 pandemic as the information becomes available.*

The entire contents of this document up to date on the 25th May 2020. Due to the fluency of the current situation, information changes daily. Please therefore visit our website www.docweb.co.za for the latest, updated information.

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Your Qualicare Doctor
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