COLLECTIVE AGREEMENT

ON THE MANAGEMENT OF MEDICALLY INCAPACITATED EMPLOYEES

IN THE CITY OF TSHWANE METROPOLITAN MUNICIPALITY

Entered by and between:

CITY OF TSHWANE METROPOLITAN MUNICIPALITY
(Hereinafter referred to as CTMM)

INDEPENDENT MUNICIPAL AND ALLIED TRADE UNION
(Hereinafter referred to as IMATU)

and

SOUTH AFRICAN MUNICIPAL WORKERS UNION
(Hereinafter referred to as SAMWU)

As parties to the SALGBC, Tshwane Division of the South African Local Government

Bargaining Council

WHEREAS the council resolution dated 28 May 2026 and the Executive Committee (EXCO) dated 13 May 2026 seeks approval for the implementation of the revised Collective Agreement on the Management of Medically Incapacitated Employees within the City of Tshwane.

WHEREAS the Occupational Health and Safety Operations Management Subsection has developed a comprehensive policy to regulate the management of employees who experience temporary or permanent medical incapacity due to illness or injury.

WHEREAS the CTMM and IMATU and SAMWU, constitute the Tshwane Division of the South African Local Government Bargaining Council (SALGBC).

WHEAREAS this revision seeks to strengthen governance, improve operational efficiency, and enhance compliance with applicable legislation including the Labour Relations Act, the Occupational Health and Safety Act and the Protection of Personal Information Act.

WHEAREAS the existing Collective Agreement required refinement to improve clarity of roles and accountability.

WHEAREAS to further strengthen the internal capacity within the Occupational Health

As Parties to the SALGBC, the Tshwane Division, agrees on the following terms and conditions:

1. INTRODUCTION

The management and administration of medical incapacity take place in accordance with the provisions of the Code of Good Practice: Dismissal; published in Government Gazette No. 53294 on 4 September 2025, under Notice No. 3470 of 2025, to ensure compliance with these requirements, the Collective Agreement must be adhered to, and the procedure must take not more than twelve months (1 Year) to be finalized.

2. PURPOSE

The purpose of this document is a guide for the management and administration of cases where employees are experiencing temporary or permanent incapacity to perform their duties due to a medical condition, illness or injury.

3. SCOPE

The Collective Agreement is applicable to all permanent employees of CTMM.

4. OBJECTIVE

To ensure, as far as reasonably practicable, compliance with all relevant legal requirements regarding management of medical incapacity due to ill health. To contribute to the health and well-being of all employees.

5. DEFINITIONS AND ABBREVIATIONS

Definitions:

5.1 Illness

A highly subjective, personal state in which an individual's physical, emotional, social, or spiritual functioning is diminished or impaired compared to their previous experience.

5.2 Disease

A condition that affects the structure or function of part or all of the body and is usually associated with specific signs and symptoms.

5.3 Injury

Physical damage, trauma, or harm to the body resulting from an acute, overwhelming transfer of energy (mechanical, thermal, chemical, electrical, or radiant) that exceeds the body's threshold of physiological tolerance.

5.4 Temporary employee

Hired for a limited time to handle short-term needs like seasonal peaks, special projects, or covering for absent staff, often via an agency, and has a defined end date, potentially gaining experience.

5.5 Physical medical incapacity

An employee's inability to perform their contractual job duties, either temporarily or permanently, due to a physical injury or illness.

An employee's inability to perform their job's essential duties due to temporary or permanent ill health or injury.

5.6 Mental medical incapacity

A state where a person's decision-making ability, cognitive function or emotional stability is severely impaired due to a recognized mental illness, intellectual disability, or organic brain syndrome, rendering them unable to manage their own affairs or perform work duties.

5.7 Sensory medical incapacity

A usually long-term or permanent, impairment of an Individual's sensory organs - such as sight, hearing, touch, smell or balance — that prevents them from performing their customary work duties.

5.8 Disability

Physical, mental, sensory, or social impairments that create activity limitations and participation restrictions in a person's daily life. It represents a functional, long-term, or chronic condition, often resulting from injury, illness, or genetic factors, that affects a person's ability to perform activities of daily living (ADLs).

5.9 Aging

A gradual, continuous, and multidimensional process of natural change - affecting physical, psychological and social dimensions - that begins in early adulthood. It involves the accumulation of molecular and cellular damage over time, leading to a decline in physiological function, increased susceptibility to disease, and reduced capacity to maintain homeostasis.

5.10 Impairment

Any loss or abnormality of psychological, physiological, or anatomical structure or function, it represents a deviation from normal body structure or organ function at the organ or micro-level.

6. Abbreviations:

- MOMI - Management of Medical Incapacity
- FFW - Fitness For Work
- CTMM - City of Tshwane Metropolitan Municipality
- OH - Occupational Health
- MMI - Maximum Medical Improvement
- OMP - Occupational Medicine Practitioner
- ONP - Occupational Nursing Practitioner
- DOH - Department of Health
- AMA - American Medical Association
- IOD / OD - Injury on Duty / Occupational Disease

- NFMW - National Fund for Municipal Workers
- MEPF - Municipal Employee Pension Fund
- MGF - Municipal Gratuity Fund
- SALA - South African Local Authorities Pension Fund
- MWRF - Municipal Worker Retirement Fund
- PFA - Pension Fund Adjudicator
- SPMI - Support Person for Medical Incapacity

7. LEGISLATION AND REGULATION FRAMEWORK

The Legislative and regulatory framework includes, but is not limited to the following:

- Labour Relations Act, 66 of 1995, Schedule 8 (LRA)
  Employment Equity Act, 55 of 1998 (EEA) in relation to disability
- Occupational Health and Safety Act, 85 of 1993 (OHSA or OHS Act) in relation to injuries on duty
- Local Government Municipal Finance Management Act 56 of 2003 (MFMA)
- Compensation for Occupational Injuries and Diseases Act. 130 of 1993 (COIDA)
- Protection of Personal Information Act No. 4 of 2013 (POPI)
- Promotion of Equality and Unfair Discrimination Act
- National Health Act

8. RELATED DOCUMENTS

Annexure A — Application by Employee
Annexure B — Declaration by Employee
Annexure C — Medical Report (Confidential)
Annexure D — Departmental Response
Annexure E — Department Application
Annexure F — Departmental Notice
Annexure G — Employee Response
Annexure I — Outcome of Fitness for Work Medical Evaluation
Annexure J — Notice to Employee of Outcome
Annexure K — Appeal from Employee
Annexure L — Deduction of costs after unsuccessful appeal
Annexure M — Outcome of Appeal
Annexure N — Departmental notice to employee of appeal
Annexure O — Payment for Medical Specialist and Medical Investigation
Annexure P — Notice of alternative work
Annexure Q — Alternative placement due to medical incapacity

9. CONTENTS

9.1 The Occupational Health and Safety Operations Management Subsection render a comprehensive occupational health service to the City of Tshwane (CTMM) and permanent employees to -

- maintain and promote the health of all its employees while at work;
- comply with legislation; and
- prevent loss of productivity

9.2 The Employer shall treat any employee who is incapacitated due to illness or injury in a consistent, fair and appropriate manner with regard to the employee's particular circumstances. No employee shall be subject to any form of victimization or unfair discrimination as a result of their incapacity and the Employer shall maintain high levels of confidentiality when managing incapacity.

9.3 The degree of the incapacity as well as the permanency of the incapacity shall be factors when assessing an employee's suitability for ongoing employment. The Employer shall ensure that termination arising from incapacity due to ill health (mental or physical) or injury shall be in accordance with the provisions of the Code of Good Practice: Dismissal; published in Government Gazette No. 53294 on 4 September 2025, under Notice No. 3470 of 2025.

10. Categories

Applicants for evaluation of medical incapacity are categorised to distinguish between:

10.1 Permanent medical incapacitation:

10.1.1 Scenario A: Employees experiencing permanent medical incapacitation, unable to perform any work.

10.1.2 Scenario B: Employees experiencing permanent medical incapacitation, unable to perform their current work.

10.1.3 Scenario C: Employees experiencing permanent medical incapacitation, but who can perform their own work with certain adaptations.

10.2 Temporary medical incapacitation

10.2.1 Scenario D: Employees experiencing temporarily medical incapacitation, unfit to perform their own work.

10.2.2 Scenario E: Employees experiencing temporarily medical incapacitation, unfit to perform any kind of work.

10.3 The management of each of the aforementioned scenarios is as follows:

10.3.1 Scenario A: The service is terminated on grounds of permanent medical incapacity.

10.3.2 Scenario B: An investigation is done with a view of redeployment in accordance with approved procedures.

10.3.3 Scenario C: Adaptation of the duties or work circumstances of the employee.

10.3.4 Scenario D: Alternative temporary redeployment in accordance with approved procedures will be arranged. During this period of convalescence counselling and rehabilitation may be required.

10.3.5 Scenario E: if the period of this temporary illness is unreasonably long and especially when the term or duration of incapacity is uncertain, the case will be referred to the Settlement Committee.

- Non-IOD cases: All sick and vacation leave have been utilised,
  IOD cases: A total of 365 calendar days may not be exceeded.
- Due to factors such as unsatisfactory response on treatment, counselling and rehabilitation.

The "Maximum Medical Improvement" (MMI) period is based on 12 months.

11. ROLE PLAYERS AND RESPONSIBILITIES

11.1 HEADS OF DEPARTMENTS MANAGEMENT

11.1.1 The departments are required to consider each case individually. Initiate the incapacity process when necessary.

11.1.2 Interventions by managers include simple investigation to confirm facts, discussion with the employee where the employee needs assistance in formal incapacity proceedings.

11.1.3 Incapacity procedure should be activated by the manager through regular monitoring of employees leave records

11.1.4 In instances where a possible incapacity problem has been identified, the manager shall be required to follow the procedure. Failure to do so may result in disciplinary action against the manager and possible liability in terms of the MFMA in cases of fruitless and wasteful expenditure. Such fruitless and wasteful expenditure may arise in situations where late application is made, and the employer is required to incur additional costs in lieu of disability or other benefits.

11.1.5 Regular analysis of sick leave absenteeism by the direct manager to identify employees with high frequency absenteeism or those with long periods of absenteeism, usually longer than six weeks.

11.1.6 The direct manager must monitor medical certificates from treating specialists indicating an employee with medical incapacity and refer the employee to Occupational health. (with the employee's consent)

11.1.7 Explore alternative and reasonable accommodation.

11.1.8 Ensure a fair hearing before any final decision.

11.2 EMPLOYEE

11.2.1 Employee self-reporting: Wherever there is reason to be concerned about any employee identified by one of these means, such instance should be Investigated to determine possible medical incapacity.

11.2.2 Departments, or an employee him/herself, may request a fitness for work examination when of the opinion that the work performance is hampered by impairment caused by ill-health or injury.

11.3 HUMAN RESOURCES

11.3.1 Guide the process, maintain record and ensure compliance with labour laws

11.3.2 Human Resources can also activate medical incapacity enquiry through corporative monitoring of records.

11.3.3 Facilitate meetings and communication.

For a formal application refer to the procedure for Management of Medical Incapacitated employees.

The application will be evaluated by Occupational Health, and a recommendation will be made by the Occupational Health Panel in accordance with approved procedure.

12. OCCUPATIONAL HEALTH PANEL

12.1 The Occupational Health Panel will consist of:

(a) One or more Occupational Medical Practitioner (OMPs) who are in possession of an MBCHB degree. Diploma in Occupational Health (DOH), and AMA Guides training (as an advantage).

(b) The permanently employed Chief Occupational Nursing Practitioner and one or more Occupational Nursing Practitioners (ONPs), who holds a postgraduate diploma in Occupational Health Nursing, following a Diploma or Bachelor's Nursing Degree.

(c) The Senior Specialist for Occupational Health Operations Management, who will be the chairperson of the Panel and who are in possession of an MBCHB degree, Diploma in Occupational Health (DOH), and AMA Guides training (as an advantage).

(d) Optionally, two or more permanently employed Occupational Nursing Practitioners, within the City of Tshwane, may also form part of the Occupational Health Panel.

(e) Quorum should consist of 4 or more members of the above.

***NOTE:** Should the need arise for complicated cases to be referred; the following shall apply:
External OMP/s will be invited to further assess the case and paid a tariff according to the South African Society of Occupational Medicine's per hour rate for specialist OMPs. A majority decision will be binding on all parties.

12.2. The decision of the Panel will be based on the employee's Specialist Medical report/s and or Occupational Therapist report.

12.3. The Panel may, at the cost of the employer, refer an employee to a specialist for a second opinion should such an opinion be needed.

12.4 Referrals to an Occupational Therapist for a Functional Capacity Evaluation may be requested by the Panel if they are of the opinion that the employee will still be able to be productive, (not necessarily in the employee's department or job title) and to determine what functions the employee can still perform.

12.5 Medical reports that City of Tshwane paid for, remains the property of City of Tshwane.

12.6 In a case whereby the employee requires to know the contents thereof the OMP will discuss the report with the employee.

12.6.1 If the employee requests a hard copy of the report the employee will be liable for the full amount of the costs of such a report.

12.6.2 According to the POPI Act, the employee needs to sign a letter of consent for the release of medical records by the specialist they were referred to by Occupational Health.

13. APPEAL

The employee may, in accordance with approved procedure appeal against the recommendation of the Panel within 30 calendar days. The appeal will be handed jointly by the Department concerned and Occupational Health. In anticipation of the outcome of the appeal the following prerequisites will be applicable:

(a) In cases where the termination of service is **not recommended** the recommendation of the Panel will be applicable.

(b) In cases where the termination of service is **recommended** sick leave must be taken.

(c) In case of a successful appeal, the costs of independent specialist will be paid by the employer.

(d) In case the appeal was unsuccessful the employee will be liable for the costs which will be deducted from the employee's salary.

(e) If the employee refuses to sign possible liability, the appeal is deemed to have failed, and the decision of the Panel's first outcome will still be valid.

NOTE: The employee must complete a form (Annexure L) for the deduction of cost for the referral to an independent specialist.

14. REPORTING OF DISABILITY AND RISK CLAIMS

14.1. Managers/Supervisors must inform the employee's respective pension/provident fund (NFMW, MEPF, MGF, SALA, MWRF) as well as the Tshwane Group Life Scheme to register a potential claim for risk cover. Each of the above funds and the Tshwane Group Life Scheme have a certain period in which they must receive written notification from the employer that a member is a potential disability for the fund. Claims must be registered within 3 months by written notification.

14.2. If a fund is notified late it could result in a claim being repudiated/declined by the insurer. This will result in non-payment from the insurer to the fund and the member will not receive the additional funds for disability although he/she might qualify for it because of the seriousness of the illness. This can lead to a claim by the member to the PFA against the employer and/or fund for non-compliance to the Collective Agreement of the fund.

14.3. If the department becomes aware of an employee booked off for longer than 6 weeks or constant taking sick leave for the same condition or has a serious illness or injury the situation must be reported to the member's fund and the Tshwane Group Life Scheme. The fund will then send a form to be completed to report a potential claim. Occupational Health must also be informed of all potential claims.

15. MANAGEMENT OF SICK LEAVE

15.1. It is the responsibility of the Department to monitor an employee's sick leave, conduct sick absenteeism counselling and to refer cases to Occupational Health if there is no improvement following counselling before an employee's sick leave is exhausted,

15.2. The department should then send a request to: Divisional Head: Human Capital Recruitment and Admin Management for possible extension of the employee's sick leave to enable Occupational Health to finalize the investigation within the 12-month period.

16. REDEPLOYMENT

16.1 In the event of redeployment the following guidelines will be followed:

(a) Where an employee does not possess the formal appointment requirements for an available post, but possesses the necessary potential or skills required for the post, he/she will be accommodated by waiving the formal appointment requirements.

(b) In the redeployment of ill-health cases, the normal selection procedures will not be applied.

(c) An employee will be redeployed with retention of his/her current salary notch but with 6 (six) months phasing out period of allowances which were coupled to the previous post but are not applicable anymore to the new post. In the case of redeployment in a post with a lower job evaluation level as the previous post the employee will retain his/her current salary notch until the upper salary notch of the

new post has been adjusted to the same or a higher level. Redeployment can however not occur to a post on a higher job level as such is considered as a promotion.

(d) All cases where an employee can't be redeployed successfully as well as all cases where an employee rejects an alternative job offer will be referred to the Settlement Committee.

16.2 The Settlement Committee will consist of the following members:

- The City Manager or nominee
- Group Head: Group Human Capital Management or nominee
- Divisional Head: Human Capital Recruitment and Admin Management
- Divisional Head: Labour Relations or nominee.
- Relevant Departmental Group Head or nominee (The nominee must be functioning at the level of Group Head or above and be delegated to make binding decisions on behalf of the Head of the Department).
- Chairperson (Occupational Medicine Practitioner) of the Occupational Health Panel / nominee.
- Director: Occupational Health and Safety or nominee.
- One representative of each of the unions recognised by the CTMM.
- Independent Medical Specialist.

The City Manager or his/her nominee and the Group Head: Group Human Capital Management with three other members will be able to form a quorum.

16.3 The Settlement Committee will deal with medical incapacity within its discretion and will have the authority to:

(a) Instruct a department to accommodate an employee in a specific vacant post.

(b) Terminate the services of an employee due to medical incapacity.

(c) Terminate the services of an employee on the grounds of incapacity after an unsuccessful redeployment attempt.

(d) Terminate the services of an employee on the grounds of incapacity due to the employee's refusal to accept an alternative job, offer.

16.4 A majority decision will be binding on all parties, in case of an equal vote, the decision of the Chairperson of the Settlement Committee will be binding on all parties.

16.5 Since the termination of services which are referred to in paragraphs 16.3 (b), (c) and (d) is a result of an employee's incapacity and not because of redundancy or operational requirements, no severance benefits will be applicable.

16.6 In the process of investigating and managing the alleged medical incapacity, the employee will be allowed the opportunity to state a case in response and to be assisted by a trade union representative or a fellow employee.

17. PROCESS OF SUBMISSION

17.1.APPLICATION BY AN EMPLOYEE

17.1.1 Decision to apply

An employee can apply based on his or her own decision or on the advice of a medical practitioner. The employee must report to his or her supervisor and the department's Support Person for Medical Incapacity (SPMI) who will give the employee guidance and assist with the application

17.1.2. Documentation to be provided

The SPMI will explain the procedure to the employee and will hand the employee the following forms:

- The employee application form (Annexure A)
- A declaration form (Annexure B)
- The medical report form (Annexure C)

The employee may be assisted by a labour union representative or a colleague during this process.

The employee must complete the application form, read and sign the declaration form and have the medical report completed by the treating specialist medical practitioner at the employee's own cost. Annexure C can be replaced by an equivalent medical report.

Additional supporting medical reports by health care practitioners may also be obtained at the employee's own cost and be submitted.

17.1.3. Employer's response to the application

The SPMI will inform the employee's supervisor/manager about the application. The SPMI will give the supervisor/manager a form (Annexure D) in which the employer's response has to be indicated. The supervisor/manager must complete the form and hand it back to the SPMI.

17.1.4 Request to Occupational Health

The SPMI will forward a request for an evaluation to the head of Occupational Health,

The following documents and forms (completed) must be attached to the request form:

- The employee's application form (Annexure A)
- The declaration form (Annexure B)
- The medical report form (Annexure C) or an equivalent medical report
- The departmental response form (Annexure D)
- The previous two years' leave records of the applicant (vacation, sick and other)
- The applicant's job description

- All medical reports available (Medical reports to be submitted directly to Occupational Health).

17.2 APPLICATION BY THE EMPLOYER

17.2.1 Decision to apply

A line manager/supervisor may decide that an employee's circumstances are such that a departmental application for a fitness-for-work medical evaluation is needed. This manager/supervisor must seek advice from his or her own department's SPMI.

17.2.2 Documentation to be provided

The SPMI will inform the manager supervisor of the procedure and will provide the following form and notice:

- A request form (Annexure E)
- The departmental notice to the employee about the departmental request (Annexure F).

17.2.3 Notification to the employee

The manager/supervisor must prepare the departmental notice (as set out in Annexure F) and hand it to the employee. The manager/supervisor must inform the employee verbally of the date of the consultation and also tell the employee that he or she can be assisted by a labour union representative or a colleague.

17.2.4 Consultation with the employee

The SPMI and the manager/supervisor will consult with the employee, explaining the reasons for believing that an evaluation would be appropriate and also explaining the process to be followed.

17.2.5 Employee's response to the application

After the meeting, the employee must complete the employee response form (as set out in Annexure G) to indicate whether or not he she supports an evaluation. The employee must hand the completed form to the SPMI.

17.2.6 Request to Occupational Health

The SPMI will forward a request for an evaluation to the head of Occupational Health.

The following documents must be attached to the request form;

- Request for fitness-for-work evaluation form (Annexure E)
- The employee's response (Annexure G)
- The employee's previous two years leave records (vacation, sick and other)
- The employees job description
- All medical reports available (Medical reports to be submitted directly to Occupational Health).

17.3 Appointment

An appointment will be scheduled by Occupational Health in writing, and the Department informs the employee about the appointment. If the employee fails to keep the appointment on two occasions, the application is terminated.

17.4 Evaluation

The OMP evacuates the employee and may request further examinations or reports if the information provided is inadequate.
If the employee fails to submit such information within 6 (six) weeks after being requested to do so, the application for the evaluation will be terminated.

17.5 Panel decision

The investigating OMP presents the case at the Occupational Health Panel. The Panel evaluates the application, categorises the case and makes recommendations accordingly.
Outcome letters will be sent out for the contact person of the Department,

Support person for medical incapacity to inform the employee by using Annexure J and advise the employee of the right to appeal by using Annexure K should the employee not support the decision. Annexure J and K to be sent back to Occupational Health within 30 days (one calendar month).

18. COMMUNICATION

A corporate circular will inform all departments of the Management of Medically incapacitated Employees Framework, the supporting procedures, appropriate guidelines, and other related documents. This information will also be distributed through the respective key account specialists of the relevant departments.

19. GENERAL

19.1. This collective agreement constitutes the full agreement between the parties on the matters addressed herein.

19.2. If any provision of this collective agreement is found to be unlawful or unenforceable, the remaining provisions remain in force to the extent permitted by law.

19.3. Should this collective agreement conflict with any existing policy, this collective agreement shall prevail.

19.4. Should any future realignment, change in legislation, national directive or any other circumstance creates a conflict with this collective agreement, this agreement must be amended to reflect such changes.

19.5. Headings are used for convenience and do not affect interpretation.

20. DISPUTE RESOLUTION

20.1 Any dispute about the interpretation, application or implementation of this collective agreement must be dealt with through the dispute resolution processes of the SALGBC Tshwane Division.

21. AMENDMENT AND REVIEW

21.1 No amendment, variation or addition to this collective agreement is valid unless it is recorded in writing and signed by the parties through the appropriate bargaining structures.

21.2 A review of this collective agreement may be undertaken by mutual agreement between the parties. A review does not change this collective agreement unless a written amendment is concluded and signed.

22. RATIFICATION

22.1. This collective agreement will be submitted for ratification by the Tshwane Division of the SALGBC at the first meeting of this division of the SALGBC, following signature of this collective agreement.

22.2. This collective agreement binds the parties to the agreement and all employees who are not members of a registered trade union admitted to the SALGBC, as well as all members of registered unions admitted to the SALGBC who are not parties to this agreement.

T.T.

L.D.

Signed on behalf of the **CITY OF TSHWANE METROPOLITAN MUNICIPALITY** (CTMM) at **Pretoria** on this 9 day of November 2026 in the presence of the undersigned witnesses.

Signature: _____ Name in Full: Johanna M du Toit.

Capacity: Chief Occupational Nursing Practitioner

AS WITNESSES:

1. _____

2. _____

Signed on behalf of the **INDEPENDENT MUNICIPAL AND ALLIED TRADE UNION (IMATU)** at **Pretoria** on this 9th day of November. 2026 in the presence of the undersigned witnesses.

Signature: _____ Name in Full: Wynand Potgieter.

Capacity: Regional Chairperson

AS WITNESSES:

1. _____

2. _____

Signed on behalf of the **SOUTH AFRICAN MUNICIPAL WORKERS UNION (SAMWU)** at **Pretoria** on this 09 day of 11 2026 in the presence of the undersigned witnesses.

Signature: _____ Name in Full: NAKAMPE DONALD NANAKUISI

Capacity: REGIONAL SECRETARY

AS WITNESSES:

1. _____

2. _____

T.J.

TA
NO
L.D.

Signed on behalf of the **SOUTH AFRICAN LOCAL GOVERNMENT BARGAINING COUNCIL (SALGBC)** at **Pretoria** on this 09 day of November 2026 in the presence of the undersigned witnesses.

Signature: _____ Name in Full: E.L. Setagwela

Capacity: Regional Secretary: Gauteng

F.T.

T/A

NO

I.D.

ANNEXURE A

CITY OF TSHWANE

APPLICATION BY EMPLOYEE FOR FITNESS-FOR-WORK MEDICAL EVALUATION

Name and surname: _____

Pay number: _____

Department/directorate: _____

Division: _____

Designation: _____

Date: _____

Dear _____ [Head of the Section]

I believe that I am currently incapable of efficiently performing my duties in the post I occupy because of infirmity of mind/body.

I am hereby applying to undergo a medical evaluation to determine my fitness for work in terms of the Municipality's policy on the management of medically incapacitated employees.

I acknowledge that this application could lead to the termination of my services due to medical incapacity.

I have read and understood the attached declaration and have signed my initials at every paragraph. I have signed the declaration itself in full.

Please assist me with my application by providing me with the following (*indicate with an X*):

☐ A COPY OF THE STANDARD MEDICAL REPORT FORM (Annexure C), which I need to submit to a specialist practitioner or Occupational Therapist of my choice, who will medically examine me, at my own cost, and complete the form (which I will return to my employer)

☐ ADVICE AND ASSISTANCE WITH MY APPLICATION

Thank you for your assistance.

Yours faithfully

_____

ANNEXURE B

CITY OF TSHWANE

DECLARATION BY EMPLOYEE

Employee: Mr/Ms _____

Pay number: _____

Department/directorate: _____

(Please read the declaration below carefully before signing in the space provided for your signature. Sign your initials at each paragraph.)

1. I acknowledge and understand that my duty to disclose all relevant information includes disclosing all information relating to my health and previous medical history, as this will enable the application for a medical evaluation of my fitness for work and the possible termination of my services due to medical incapacity to be properly assessed to determine my state of health, which could lead to the termination of my services due to medical incapacity.

   Initials: _____

2. I declare that all the information and details I will furnish to my employer, or any examining medical doctor, practitioner or specialist in support of the application for a medical evaluation of my fitness for work and the possible termination of my services for medical reasons, will be true and accurate to the best of my knowledge. I undertake not to withhold, omit or conceal any medical or other information which my employer could reasonably require to assess the application for a medical evaluation of my fitness for work.

   Initials: _____

3. I am aware that supplying false, inaccurate or incomplete information and details in support of the application for a medical evaluation of my fitness for work and the possible termination of my services due to medical incapacity may in appropriate circumstances be seen as disciplinary misconduct. I am aware that if I am found guilty of such misconduct, a disciplinary penalty, which could include dismissal, could be imposed against me.

   Initials: _____

4. I hereby irrevocably authorise my employer to obtain any information that it, in its sole discretion, considers necessary with regard to my health and employment circumstances from any person who has such information available. I hereby indemnify any such person against any legal action whatsoever arising from the supplying of the information. I undertake to sign the necessary consent in this matter if required to do so.

   Initials: _____

5. I agree and consent to any necessary or appropriate medical or other investigation relating to the information or details about my medical health or employment circumstances which I will be providing or have already provided or which I could be required to provide. I am aware that my employer may require medical specialists or Occupational Therapist to undertake full examinations of me, and I confirm my willingness to cooperate and to participate in any medically related examinations which could be considered necessary.

   Initials: _____

6. I hereby authorise, consent to and instruct any medical practitioner, hospital, clinic, institution, specialist or similar person or body, which is currently or could be in possession of (or may in future come into possession of) any information or knowledge concerning my past, present or future state of health, to disclose and make this information or knowledge available to my employer. I further declare that this authorisation, consent and instruction must remain valid before and after my death, if it occurs.

   Initials: _____

7. I hereby indemnify my employer, my employer's employees and any medical officer designated by my employer for medical examination purposes against any claims arising from any medical examinations, reports and recommendations and the consequences of them.

   Initials: _____

Signed at _____ on this the _____ day of _____ 20____

Employee's signature: _____

ANNEXURE C

CITY OF TSHWANE
IGNITING EXCELLENCE

MEDICAL REPORT - FITNESS FOR WORK

Contact detail of the person who **sends** the patient:

Contact person:	
Tel:	E-mail:
Department:	Section/Unit:

Ref no of the health professional who **completes** the form:

1. REASON FOR EXAMINATION

2. INTRODUCTION

A clear, accurate and complete report with specific reference to the reason for the examination is fundamental to determining impairment, whether complete or partial, temporary or permanent. Wherever possible, please give objective clinical measurements in support of findings as to the presence/absence of permanent medical impairment, and identify, clarify or explain apparent or obvious inconsistencies. Please note that the Occupational Health Panel of the Municipality will decide on incapacity. Note further that the employee is liable for payment for this report.

3. EMPLOYEE DETAILS

Names in full:	
Job title:	
Telephone number: Home:	Telephone number: Work:
Telephone number: Cell:	ID number or date of birth:
Gender:	Pay number:
Department:	Section:

4. OCCUPATIONAL ACTIVITIES *(List 3 to 5 key activities.)*

Usual	***At present***

5. CLINICAL HISTORY *(Employee's explanation of impairment – **to be completed by medical examiner**)*

5.1	Describe in detail the cause, nature and extent of the impairment.

5.2 Describe what treatment he/she has received for this impairment to date and the results of the treatment.

5.3 Is he/she still under treatment? If yes, state what treatment, and give the name and address of the doctor, specialist or hospital.

5.4 Is any further treatment or operation contemplated? If yes, state nature and date.

5.5 Which of the present occupational activities is he/she able to perform efficiently?

5.6 Does the patient or you have any suggestions on changes to his/her occupational activities to accommodate the impairment?

6. MEDICAL HISTORY *(To be completed by medical examiner)*

	YES	NO		YES	NO		YES	NO
Heart disease, vascular disease or high blood pressure			Mental or psychological disorders/phobias			Diseases of muscle, bone, joints, back		
Hearing/speech disorder			Asthma, lung disease, chronic cough			Any other illness or injury		
Neurological disorder, e.g. headache, dizziness, fits			Stomach, liver or intestinal trouble			Diabetes mellitus		
Eye or vision trouble (except glasses)			Malignant tumours or cancer			Other		

7. WHAT SPORT/HOBBIES DO/DID HE/SHE PARTICIPATE IN?

REMARKS *(To be completed by the medical examiner. Please comment in detail on all items marked YES.)*

8. DECLARATION BY EMPLOYEE

I declare and confirm that all the information and details I have provided in this form are true and accurate to the best of my knowledge. I declare and confirm that no medical or other information which my employer/doctor could reasonably require to consider and assess the application for an evaluation of my fitness for work has been deliberately withheld, omitted or concealed.

I am aware that supplying false, inaccurate or incomplete information and details could in appropriate circumstances constitute disciplinary misconduct and that, if I were to be found guilty of such misconduct, a disciplinary penalty, which could include dismissal, could be imposed against me.

Signed at ..... on this..... day of ..... 20.....

.....	.....
Employee	Witness: Medical examiner

9. CLINICAL EVALUATION

CLINICAL FINDINGS AND OCCUPATIONAL IMPAIRMENT
Describe all abnormalities and the nature and extent of the impairment in detail – use additional sheets if necessary.

SPECIAL INVESTIGATIONS AND DIAGNOSTIC PROCEDURES
Please attach all reports and findings, including physiotherapy, occupational therapy, etc.

What would help the patient to carry out his / her usual activities to meet personal, social and occupational demands? For example, accommodation, including restrictions, assistance devices and rehabilitation programmes (describe briefly).

10. DECLARATION BY THE MEDICAL EXAMINER

I, Dr ....., declare that I personally completed this medical report and examined the employee on (date) ..... 20.....

A medical impairment is:	**Absent**	**Present**	And it is:	**Temporary**	**Permanent**

Signature:	Address:
Qualifications:	
Telephone number:	
Date:	

11. PANEL

Date:
Decision:

ANNEXURE D

CITY OF TSHWANE

[DEPARTMENTAL LETTERHEAD]

STRICTLY CONFIDENTIAL

THE CHAIRPERSON: OCCUPATIONAL HEALTH PANEL
CORPORATE AND SHARED SERVICES DEPARTMENT

DEPARTMENTAL RESPONSE TO THE APPLICATION FOR A FITNESS-FOR-WORK EXAMINATION OF MR/MS _____, PAY NO _____, _____ *(designation)*, _____ DIVISION

I, Mr/Ms _____, as the line manager/supervisor of the above employee, have been notified that the employee has applied for a medical examination to determine his/her fitness for work and the possible termination of his/her services due to medical incapacity.

I would like to respond by *(indicate with an X)*:

☐ SUPPORTING THE APPLICATION

☐ NOT SUPPORTING THE APPLICATION

The reasons for my response are as follows:

_____

_____

_____

_____

_____

_____ _____

HEAD OF SECTION DATE

ANNEXURE E

CITY OF TSHWANE

[LETTERHEAD OF RELEVANT DEPARTMENT]

Date: _____

THE CHAIRPERSON: OCCUPATIONAL HEALTH PANEL
CORPORATE AND SHARED SERVICES DEPARTMENT

REQUEST FOR FITNESS-FOR-WORK MEDICAL EVALUATION

The details of the employee for which an evaluation is requested are as follows:

Name: Mr/Ms _____ Pay number: _____

Designation: _____ Division: _____

Section: _____ Depot/building: _____

Owing to the employee's possible ill-health, this department requests a medical evaluation to determine the employee's fitness for work and recommendations on the employee's continued employment and, if applicable, the employee's future working conditions, workplace, job content, etc.

The real and full reasons for this request are as follows:

_____

_____

_____

The employee's response to this departmental request is attached. A meeting to discuss this with the employee was held on _____.

The following are attached:

- Leave record for the past two years
- Complete job description
- All available medical reports

_____
HEAD OF SECTION

ANNEXURE F

CITY OF TSHWANE

[LETTERHEAD OF RELEVANT DEPARTMENT]

Date: _____

Dear Mr/Ms .....

DEPARTMENTAL NOTICE OF REQUEST FOR FITNESS-FOR-WORK MEDICAL EVALUATION

An application for a fitness-for-work medical evaluation was received from your line manager/supervisor.

It appears that you may be incapable of efficiently discharging your duties in the post you currently occupy. As this could be caused by ill-health or incapacity, I would like to consult you to discuss with you matters such as:

- Your current workplace circumstances
- The reasons why you may be incapable of efficiently discharging your duties
- Your present state of health, if you wish to discuss this, although you are free not to do so
- Whether you require any health or employee assistance services at this stage
- What other forms of assistance you may require and which we could make available
- The administrative process for fitness-for-work medical evaluations and appeals
- The consequences of termination of services due to medical incapacity
- Your rights in responding to this notice of a request for a medical evaluation
- Your rights in responding to the outcome of the evaluation
- Any relevant documents you would like to study and respond to

You will be contacted soon to arrange a time for us to discuss these details and to make arrangements to provide the information you need. If you so require, you may be assisted by your union representative or a colleague.

Yours faithfully

_____

HEAD OF SECTION

ANNEXURE G

CITY OF TSHWANE

STRICTLY CONFIDENTIAL

Tel: _____

Date: _____

TO: THE HEAD OF DEPARTMENT
..... DEPARTMENT

EMPLOYEE'S RESPONSE TO THE DEPARTMENTAL REQUEST FOR A FITNESS-FOR-WORK EVALUATION – MR/MS _____, PAY NO _____,
_____ *(designation)*, _____ DIVISION

I have been informed that the Department is requesting a medical examination to determine my medical fitness for work.

I wish to respond by *(indicate with an X)*:

☐ SUPPORTING THE APPLICATION

☐ NOT SUPPORTING THE APPLICATION

The reasons for my response are as follows:

_____

_____

_____

_____

Yours faithfully

_____
(EMPLOYEE)

ANNEXURE I (A)

CITY OF TSHWANE
IGNITING EXCELLENCE

Group Human Capital Management

Occupational Health Operations Management

Room HS17 | 1ST Floor | Tshwane House | 320 Madiba Street | Pretoria | 0002
PO Box 440 | Pretoria | 0001
Tel: 012 358 4018/012 358 4052 | Fax: 086 533 3942
Email: geraldg@tshwane.gov.za | www.tshwane.gov.za | www.facebook.com/CityOf Tshwane

My ref: 0123456
Your ref:
Contact person: Dr (Surname)
Section: OEHSW

Tel: 012 358 0660
Email:

Sub Section: Occupational Health Operations Management

Date: _____

THE GROUP HEAD: _____
(Section)
City of Tshwane

Attention: Mr / Mrs _____

OUTCOME OF FITNESS-FOR-WORK MEDICAL EVALUATION: MR / MRS _____

The Occupational Health Panel, at its meeting held on _____ at _____, found Mr / Mrs _____ to be _____(Fit / Fit for Alternative) _____.

* The following recommendations are made concerning his/her job content, workplace, etc:

_____

_____

Note:

1. The employee must be informed within 5 working days of the outcome by using Annexure J. A copy must be sent to the Chairperson of the Occupational Health Panel and a copy must be placed on his personal file.
2. The employee must complete Annexure K and has one calendar month to appeal against the decision. The completed Annexure K must be sent to the Chairperson of the Occupational Health Panel and a copy must be placed on his personal file.

Yours faithfully,

Dr (Surname)
Senior Specialist: Occupational Health Operations Management

pp Occupational Health Panel

ANNEXURE I (B)

CITY OF TSHWANE
IGNITING EXCELLENCE

Group Human Capital Management

Occupational Health Operations Management

Room HS17 | 1ST Floor | Tshwane House | 320 Madiba Street | Pretoria | 0002
PO Box 440 | Pretoria | 0001
Tel: 012 358 4018/012 358 4052 | Fax: 086 533 3942
Email: geraldg@tshwane.gov.za | www.tshwane.gov.za | www.facebook.com/CityOf Tshwane

My ref: 0123456
Your ref:
Contact person: Dr (Surname)
Section: OEHSW

Tel: 012 358 0660
Email:

Sub Section: Occupational Health Operations Management

Date: _____

THE GROUP HEAD: _____
(Section)
City of Tshwane

Attention: Mr / Mrs _____

OUTCOME OF FITNESS-FOR-WORK MEDICAL EVALUATION: MR / MRS _____

The Occupational Health Panel, at its meeting held on _____ at _____, found Mr / Mrs _____ to be _____(Unfit)_____.

* You are requested to arrange for the termination of his/her services on the grounds of permanent medical incapacity.

Note:

1. The employee must be informed within 5 working days of the outcome by using Annexure J. A copy must be sent to the Chairperson of the Occupational Health Panel and a copy must be placed on his personal file.
2. The employee must complete Annexure K and has one calendar month to appeal against the decision. The completed Annexure K must be sent to the Chairperson of the Occupational Health Panel and a copy must be placed on his personal file.
3. The employee is herewith put on sick leave until the employee's service is terminated or until the Panel changed its decision.

Yours faithfully,

Dr (Surname)
Senior Specialist: Occupational Health Operations Management

pp Occupational Health Panel

ANNEXURE J

CITY OF TSHWANE

[LETTERHEAD OF RELEVANT DEPARTMENT]

Please send a copy to the Chairperson at the Occupational Health Panel and place a copy on the employee's personal file.

Dear Mr/Ms _____

DEPARTMENTAL NOTICE TO EMPLOYEE OF OUTCOME OF FITNESS-FOR-WORK MEDICAL EVALUATION

(*Delete the paragraph that is not applicable.)

* The Occupational Health Panel has evaluated the information on your medical condition and has found you fit for work in the City of Tshwane, with the following conditions:

_____

_____

* The Occupational Health Panel has evaluated the information on your medical condition and has found you permanently unfit for any work in the City of Tshwane for medical reasons. We shall therefore request the termination of your services on the grounds of permanent medical incapacity.

You have to indicate your response to the outcome by completing Annexure K.
Should you decide to appeal against the decision:

- You will have to complete Annexure K and give it to your department within one calendar month from being handed this letter.
- You may choose to use your representative or make the application personally.
- You will be referred to an independent specialist best suited to your condition to evaluate you and submit a report on your fitness to work within the next 30 working days.
- In the event of your appeal being successful, Occupational Health will pay the costs of the medical examination. If your appeal is unsuccessful, you will be liable for the costs of the medical examination.
- You may provide at your own cost additional information that was not available at the Panel meeting.

Yours faithfully

_____

HEAD OF SECTION

_____ _____

Employee Date received

ANNEXURE K

CITY OF TSHWANE

My ref: _____

Your ref: _____ Date: _____

EMPLOYEE'S RESPONSE TO AND POSSIBLE APPEAL AGAINST THE OUTCOME OF THE FITNESS-FOR-WORK MEDICAL EVALUATION

You have one calendar month from receiving notice of the outcome of the Occupational Health Panel to complete this letter and hand it to your Department

The Department must sent this original letter to the Chairperson of the Occupational Health Panel within 5 working days after receiving it back from the employee and a copy must be placed on the employee's personal file.

THE HEAD OF DEPARTMENT

I have been informed that the Occupational Health Panel has found me:

* permanently medically unfit to perform any work in the City of Tshwane and has recommended that my services be terminated due to permanent medical incapacity.

OR

* not permanently medically unfit to perform work and has therefore not recommended that my services be terminated due to permanent medical incapacity.

AND

* I am not going to appeal against the outcome of the medical evaluation.

OR

* I am going to appeal against the outcome of the medical evaluation.

I understand that:

- In the event of my appeal being successful, Occupational Health will pay the costs of the specialist medical evaluation.
- In the event of my appeal being unsuccessful, I shall be liable for the costs of the specialist medical evaluation.

Yours faithfully

_____ _____

Employee Pay No

* *Tick the appropriate boxes.*

ANNEXURE L

My ref: _____

Your ref: _____ Date: _____

ESTIMATED COST OF APPEAL EXAMINATION AND PERMISSION TO DEDUCT COST OF MEDICAL EVALUATION FROM SALARY OF EMPLOYEE IF APPEAL IS UNSUCCESSFUL

I, Mr/Mr _____,

_____ *(designation)*,

_____ Division,

Pay No _____, have been informed that the **estimated cost** of the specialist medical evaluation to be performed by _____, an independent specialist, as part of my appeal against the outcome of my fitness-for-work medical evaluation will be R_____.

I am aware that I will be liable for payment of all costs relating to the specialist medical evaluation should my appeal be unsuccessful.

I hereby give permission to the Finance Department to in the event that my appeal is unsuccessful, deduct the cost of the medical evaluation, as indicated on the invoice submitted by the specialist, from my salary in as many payments as not to exceed a total salary deduction of 25%.

Signed on this _____ day of _____ 20 _____

_____ EMPLOYEE

_____ WITNESS

ANNEXURE M

CITY OF TSHWANE
IGNITING EXCELLENCE

Group Human Capital Management

Occupational Health Operations Management

Room HS17 | 1ST Floor | Tshwane House | 320 Madiba Street | Pretoria | 0002
PO Box 440 | Pretoria | 0001
Tel: 012 358 4018/012 358 4052 | Fax: 086 533 3942
Email: geraldg@tshwane.gov.za | www.tshwane.gov.za | www.facebook.com/CityOf Tshwane

My ref:	123456	Tel:	012 358 0660
Your ref:		Fax:	
Contact person:	Dr (Surname)	Email:	
Section:	Occupational and Employee Health, Safety and Wellness		

Date: _____

THE GROUP HEAD: DEPARTMENTAL
City of Tshwane

Attention: Mr/Ms _____

OUTCOME OF APPEAL MEDICAL EVALUATION: MR/MS _____

The Occupational Health Panel, at its meeting held on _____ at _____ found Mr/Ms _____ to be _____

This implies that Mr/Ms _____'s appeal was successful/unsuccessful.

* You are requested to arrange for the termination of his/her services on the grounds of permanent medical incapacity.

* You are requested to deal with the employee as originally recommended by the Occupational Health Panel at its meeting of _____.

* The following new recommendations are made concerning:

_____

_____

*(*Delete the paragraph which is not applicable.)*

Note: The employee must be informed of the outcome by using Annexure N.

Yours faithfully,

Dr (Surname)
Senior Specialist: Occupational Health Operations Management

pp Occupational Health Panel

ANNEXURE N

CITY OF TSHWANE

[DEPARTMENTAL LETTERHEAD]

My ref: _____

Your ref: _____ Date: _____

Please place a copy in the employee's personal file.

Mr/Ms: _____

Dear Mr/Ms _____

DEPARTMENTAL NOTICE TO EMPLOYEE OF OUTCOME OF APPEAL

* Your appeal has been successful.
* Your appeal has been unsuccessful.

*You are thus fit for work in the City of Tshwane Metropolitan Municipality, with the following conditions:

_____

_____

_____

* You are thus permanently unfit for any work in the City of Tshwane for medical reasons. We shall therefore initiate the termination of your services on the grounds of permanent medical incapacity.

_____

HEAD OF SECTION

_____ _____

Employee Date received

(**Delete the paragraphs that are not applicable.)*

ANNEXURE O

CITY OF TSHWANE
IGNITING EXCELLENCE

Group Human Capital Management

Occupational Health Operations Management

Room HS17 | 1ST Floor | Tshwane House | 320 Madiba Street | Pretoria | 0002
PO Box 440 | Pretoria | 0001
Tel: 012 358 4018/012 358 4052 | Fax: 086 533 3942
Email: geraldg@tshwane.gov.za | www.tshwane.gov.za | www.facebook.com/CityOf Tshwane

My ref: 123456 Tel: 012 358 0660
Your ref: Fax:
Contact person: Dr (Surname) Email:
Section: OEHSW
Sub- Section: Occupational Health Operations Management

Date: _____

THE GROUP HEAD: FINANCIAL SERVICES
City of Tshwane

PAYMENT FOR MEDICAL SPECIALIST AND MEDICAL INVESTIGATION:

MR/MS ....., PAY NO .....

Following an appeal by Mr/Ms ..... against the decision of the Occupational Health Panel, he/she was referred to ..... , who evaluated him/her and forwarded the findings to us.

Mr/Ms ..... was informed by me of the possible costs and understood that, should the appeal be unsuccessful, he/she would be liable for the costs of the medical specialist and of the medical investigations needed by the specialist. He/she gave permission for the costs to be deducted from his/her salary in as many payments as not to exceed a total salary deduction of 25% (form attached).

The appeal was unsuccessful.

The invoices in question are attached.

Your assistance in deducting the money from his/her salary would be highly appreciated.

Dr (Surname)
Senior Specialist: Occupational Health Operations Management

pp Occupational Health Panel

CITY OF TSHWANE

ANNEXURE P

[LETTERHEAD OF RELEVANT DEPARTMENT]

My ref: _____

Your ref: _____ Date: _____

Mr/Ms: _____

Pay No: _____

Dear Mr/Ms _____

NOTICE OF DIFFERENT/ALTERNATIVE WORK SUITABLE TO YOUR CIRCUMSTANCES

This Department has evaluated the information on your medical condition, which renders you incapable of working in your current position. The following possible alternative work which could suit your abilities has been identified (a meeting to discuss these alternatives will be arranged with you soon):

1 _____

2 _____

The implications of the different alternatives for you will be as follows:

1 _____

_____

2 _____

_____

Please note that if none of the above alternatives is acceptable to you, your case will be referred to the Settlement Committee, which has the power to terminate your services.

_____

HEAD OF SECTION

1.1. TAW

ANNEXURE Q

CITY OF TSHWANE

[LETTERHEAD OF RELEVANT DEPARTMENT]

Date: _____

ALTERNATIVE PLACEMENT DUE TO MEDICAL INCAPACITY:

Mr/Ms. ..... Pay nr.....

Position..... Department.....

DECLARATION FROM THE DEPARTMENT

I acknowledge and understand that I have to disclose all relevant information relating to possible alternative service in my division in order to accommodate the abovementioned employee.

I declare and understand that all the information and details I will furnish to the Settlement Committee: Medical Incapacity will be true and accurate to the best of my knowledge and that all possible alternatives have been investigated. I declare and undertake that no information which the Settlement Committee: Medical Incapacitation could reasonably require will deliberately be withheld, omitted or concealed.

I am aware that false, inaccurate or incomplete information and/or details supplied in support of my investigation into possible alternative services for the abovementioned employee could in appropriate circumstances be seen as disciplinary misconduct.

Having taken into account all details and information about the medical incapacity of the abovementioned employee, his/her present position as indicated above and his/her possible knowledge, skills and personal qualities I declare as follows:

1. the following possible alternatives have been investigated:
   - _____
   - _____
2. that the following steps have been taken to determine/evaluate the abovementioned employee's suitability for the possible alternative positions
   - _____
   - _____
3. that the abovementioned employee has been found unsuitable for any of the above positions for the following reasons:
   - _____
   - _____

Dated at _____ on _____

_____ (Name) _____ (Job title)