

Certificate of Fitness

This is to certify that: MKHIZE MDUDUZI

Company: MNQUMES GARDEN SERVICES AND REPAIRS

Identity Number: 650215 5335 085

was examined on: 13 SEPTEMBER 2018 Occusure Clinic: NERD

AND HAS BEEN FOUND FIT TO ASSUME DUTIES AS A

BAKKIE DRIVER

Recommendations:

Referrals:

Certificate Expires: 12th SEPTEMBER 2019

The following surveillance was performed:

- ☒ Physical Examination
- ☒ Vision screening: Keystone / Snellen
- ☒ Lung function assessment
- ☒ Multidrug Screen
- ☒ Other: RANDOM BLOOD SUGAR
- ☐ Entry/monitoring audiograms
- ☐ Cannabis test
- ☐ K10/Epworth
- ☐ GGT

Lung function

FVC%		FEV1%		FEV1/FVC%		PEF%			
Audiometry		PLH		%		PD		%	
TIME	FREQ.	500KHZ	1000KHZ	2000KHZ	3000KHZ	4000KHZ	6000KHZ	8000KHZ	
	LEFT								
	RIGHT								
SECOND TEST									
TIME	FREQ.	500KHZ	1000KHZ	2000KHZ	3000KHZ	4000KHZ	6000KHZ	8000KHZ	
	LEFT								
	RIGHT								

DOCTORS COMMENTS:

DRS. P. ERASMUS & J. DO VALE INC.

MBChB / DCH

CATOMED OCCUPATIONAL HEALTH DIVISION

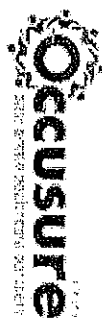
PR. NO. 1526642

BOX 213, CATO RIDGE, 3680
TEL. 031 782 2030

OCU 004 COF
WHITE

Signature of Occupational Medical Practitioner

Qualifications


NAME OF EMPLOYEE Mr Hize Mduyazi ID NUMBER 6502155335085 COMPANY NUMBER _____

It is a requirement of the Occupational Health and Safety Act, Construction regulations amendment Feb 2014 that this form is completed by the employer before the employee reports for his medical. This form is to be presented to person performing the medical examination.

* OCCUPATION e.g. Welder, General worker, Bricklayer, Steel fixer, Mobile Crane operator etc.	* POSSIBLE EXPOSURES e.g. noise, heat, fall risk, confined space etc.	* JOB SPECIFIC REQUIREMENTS e.g. Operate mobile crane, dig trenches, erecting formwork & support work etc.	* PROTECTIVE EQUIPMENT e.g. dust respirator (light duty), welding gloves etc.
DRIVER DUST NOISE	 	TRANSPORTING TOOLS REFUSE REMOVAL	OVERALL EAR PLUGS SAFETY GLASSES SAFETY BOOTS GLOVES, DUST MASK

The employer to complete all spaces marked with ★

Declaration by Medical Examiner:

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.

Occupational Medicine Practitioner/Occupational Health Nursing Practitioner (please print name)

Signature: _____

Practice Number: _____

Date: 20/2/14

Address: _____



DRS. P. ERASMUS & J. DO VALE INC.

MBChB / DOH

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