Occusure PTY LTD
passionate healthcare partners

№ 14359

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# Health Assessment for Fitness to work

*This is to certify that:* Kanyile Londiwe Faith

*Company:* Mnqubeo Garden Services and Repairs

*Identity Number:* 870101 1328 080

*was examined on:* 11 September 20 18 **Occusure Clinic:** Pietermaritzburg

***AND HAS BEEN FOUND FIT TO ASSUME DUTIES AS A***

Gardener

**RECOMMENDATIONS:**

- To manage personal medical condition
- To wear appropriate respiratory protection

**RESTRICTIONS:**

Dust

**Referrals:** Own healthcare provider

**Certificate Expires:** 09/2019

***The following surveillance was performed:***

- ✓ Physical Examination
- ✓ Vision screening: Keystone / Snellen
- ✗ ~~Lung function assessment~~
- ✗ ~~Multidrug Screen~~
- ✗ ~~Other~~.....
- ✗ ~~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:

*Signature of Occupational Medical Practitioner* RMIOHNP *Qualifications* G Veronique *Print Name*

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Occusure

NAME OF EMPLOYEE KAMYILE LOUDINE ID NUMBER 870101 1328 080 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.

| | ★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 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ★OCCUPATION e.g. Welder, General worker, Bricklayer, Steel fixer, Mobile Crane operator etc. | DUST | NOISE | | | | | | | | | | | | | | | | | | WEEDING | SWEEPING | RAKING | TRIMMING FLOWERS | | | | | | | | | | DUSTMASK, DUST MASK | EAR PLUG | SAFETY GLASSES | SAFETY BOOTS | GLOVES, HELMET |
| GARDNER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

The employer to complete all spaces marked with ★

**Declaration by MedicalExaminer:** To wear appropiate respiratory protection
To manage own personal medical condition

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)* S Veroniave

Signature: _____ Practice Number: 1369479 Date: 14/09/2018

Address: _____

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