



SAI MEDICO

HEALTH ASSESSMENT FOR FITNESS TO WORK OCCMED NO: 007

EMPLOYEE NAME: MOHSIN NAEEM RAHIM RAZAK

COMPANY: KZN COMPUTER SYSTEMS

IDENTITY NUMBER: 85 1002 5158 080

DATE OF MEDICAL: 20/11/2010

THIS CONFIRMS THE ABOVE IS:

|                                         |                                |
|-----------------------------------------|--------------------------------|
| <input checked="" type="checkbox"/> FIT | <input type="checkbox"/> UNFIT |
|-----------------------------------------|--------------------------------|

TO WORK AS CABLING TECHNICIAN

The following examinations were performed:

☒ Routine medical exam☒ 10 checklist (18/50) (Moderate distress)☒ Vision screen L(20/20)R(20/20)  
(with glasses)☒ Epworth sleep scale (5/24) (Normal)☒ Double baseline audiograms☒ Lung function (spirometry)

Lung function (available on request): Meds:

| FVC%      | FEV1%      | FEV1/FVC% | PEF%         |
|-----------|------------|-----------|--------------|
| 374 (79%) | (3.63) 92% | 97%       | 10.07 (108%) |

Audiograms: PHL: 2% PD: 1%

| Time  | Freq. | 500KHZ | 1000KHZ | 2000KHZ | 3000KHZ | 4000KHZ | 6000KHZ | 8000KHZ |
|-------|-------|--------|---------|---------|---------|---------|---------|---------|
| 12:17 | (R)   | 15     | 15      | 10      | 10      | 5       | 10      | 10      |
|       | (L)   | 10     | 15      | 15      | 10      | 10      | 5       | 20      |
| Time  | Freq. | 500KHZ | 1000KHZ | 2000KHZ | 3000KHZ | 4000KHZ | 6000KHZ | 8000KHZ |
|       | (R)   | 15     | 15      | 10      | 10      | 10      | 10      | 10      |
|       | (L)   | 10     | 10      | 10      | 5       | 10      | 15      | 20      |

Comments/recommendations: This Medical is Valid for 6 months (20/5/2011)

Occupational health practitioner (Dr. V. Munsamy SASOM SAS1471.GMP)

Monday to Friday 08h00 - 17h00

Saturday + Sunday + Public holidays: 10h00 to 14h00

After hours available until 22h00 by appointment only

Dr. V. MUNSAMY

PR No: 0707929 MP No. 0715239

MBChB (UKZN) DCH (SA)

DIP. HIV MAN. (SA)

OCCUPATIONAL HEALTH AND SAFETY ACT, 85 OF 1993

# Medical Certificate of Fitness

Co. Number \_\_\_\_\_

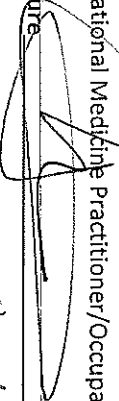
| *Possible Exposure<br>e.g. noise, heat, fall risk, confined space etc.                                                                 |  | *Job Specific Requirements<br>e.g. Operating Mobile Crane, Digging<br>Trenches, Erecting Formwork & Support<br>Work, etc.        |  | *Protective Equipment<br>e.g. Dust Respirator<br>(light Duty), Welding Gloves etc.                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| *Occupation<br>e.g. General<br>worker, Welder, Bricklayer, Steel<br>Fixer, Mobile Crane Operator, etc<br><b>Cabling<br/>Technician</b> |  | <b>DUST</b><br><b>HEIGHTS</b><br><b>CONFINED SPACES</b><br><b>FALL RISK</b><br><b>HEAT</b><br><b>ELECTRICITY</b><br><b>NOISE</b> |  | <b>CLIMBING</b><br><b>DRILLING</b><br><b>CABLING</b><br><b>WELDING</b>                                                                                           |  |
|                                                                                                                                        |  |                                                                                                                                  |  | <b>OVERALLS</b><br><b>PROTECTIVE GEAR</b><br><b>GLOVES</b><br><b>MASK</b><br><b>EAR PLUGS</b><br><b>SAFETY BOOTS</b><br><b>GOGGLES</b><br><b>REFLECTIVE GEAR</b> |  |

\*The Employer to complete the information in the spaces marked with an \* before sending the Employee for a medical examination.

**Declaration by the Medical Examiner:**

I certify that I have, by examination and testing, using the above criteria specified by the employer, satisfied myself that the above mentioned 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 **0909-929** Date **24/11/2018**

Address **6018 CHURCH STREET** **Dr. V. MUNSAMBY**

PR No. 0707929 MP No. 0715239  
MRECHB (UKZN) DCH (SA)