Dr. Vishelan Munsamy t/a
MP 071 5239
PR 0707 929
MBChb (UKZN), Dip. HIV Man (SA), Dip. Child Health (SA)
SASOM MEMBERSHIP NO. SAS1471.GMP

SAI MEDICO

Physical: 60 Boshoff Street, Pmb, 3201
Postal: PO BOX 47, Bisley, 3201
Tel: 033 342 1448
Fax: 033 342 0111
Email: admin@saimedico.co.za

HEALTH ASSESSMENT FOR FITNESS TO WORK OCCMED NO: 001

EMPLOYEE NAME: SENZO AARON MKHWANAZI

COMPANY: KZN COMPUTER SYSTEMS

IDENTITY NUMBER: 85 09 16 5611 080

DATE OF MEDICAL: 18/ 09/ 2018

THIS CONFIRMS THE ABOVE IS: FIT ~~UNFIT~~

TO WORK AS DATA CABLER

The following examinations were performed:

- ✓ Routine medical exam
- ✓ K10 checklist (10/50)
- ✓ Vision screen and acuity (20/20)
- ✓ Epworth sleep scale (0/21)
- ✓ Double baseline audiograms
- ✓ Lung function (spirometry)

Lung function (available on request): Meds: NONE (017)

FVC%	FEV1%	FEV1/FVC%	PEF%
65%	65%	85%	89%

Audiograms:

PLH = 1% PD = 0,5 %

Time	Freq.	500KHZ	1000KHZ	2000KHZ	3000KHZ	4000KHZ	6000KHZ	8000KHZ
16:30	RIGHT	10	10	10	5	0	15	15
	LEFT	10	5	5	10	10	5	10
Time	Freq.	500KHZ	1000KHZ	2000KHZ	3000KHZ	4000KHZ	6000KHZ	8000KHZ
16:56	RIGHT	10	5	5	5	5	10	10
	LEFT	10	5	5	10	10	10	15

Comments/recommendaations: Valid until 18/09/2019

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

DR V. MUNSAMY t/a

Monday to Friday 08h00 – 17h00
Saturday + Sunday + Public holidays: 10h00 to 14h00
After hours available until 22h00 by appointment only

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Annexure 3

OCCUPATIONAL HEALTH AND SAFETY ACT, 85 OF 1993 Construction Regulation, 2014

Medical Certificate of Fitness

Name of Employee Senzo. A. Mkwanazi ID Number 850916 5611 080 Co. Number _____

	*Possible Exposure e.g. noise,heat,fall risk, confined space etc.	*Job Specific Requirements e.g. Operating Mobile Crane, Digging Trenches, Erecting Formwork & Support Work, etc.	*Protective Equipment e.g. Dust Respirator (Light Duty), Welding Gloves etc.
*Occupation e.g. General worker,Welder,Bricklayer,Steel Fixer,MobileCrane Operator, etc	FALL RISK CONFINED SPACE ELECTRIC SHOCK DUST	DRILLING CABLING	EAR PLUGS GOGGLES GLOVES DUST MASK.

*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 0707929 Date 18/09/2018

Address 60 Boshoff Street . Pmb

Dr V. MUNSAMY t/a

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