ANNEXURE 3

OCCUPATIONAL HEALTH AND SAFETY ACT, 85 OF 1993
CONSTRUCTION REGULATIONS, 2014

MEDICAL CERTIFICATE OF FITNESS

Name of employee _____

ID number _____ **Company number** _____

*** Occupation**
e.g. General worker, Welder, Bricklayer, Steel fixer, Mobile crane operator

_____

*** Possible exposures**
e.g. Noise, Heat, Fall risk, Confined spaces, Dust, Hazardous chemical agents

_____

_____

*** Job specific requirements**
e.g. Operating a mobile crane, Digging trenches, Erecting formwork and support work

_____

_____

*** Protective clothing and equipment**
e.g. Dust respirator, Welding gloves, Fall arrest harness

_____

_____

*** The employer completes the information in the spaces marked with an asterisk before sending the employee for the 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 or Occupational Health Nursing Practitioner (print name) _____

_____

Signature _____ **Practice number** _____

Date of examination _____ **Expiry date** _____

This Medical Certificate of Fitness is valid for one year from the date issued.