P-Form *Please complete. Information essential for compensation claims!*

MEDICAL BUREAU FOR OCCUPATIONAL DISEASES
NATIONAL INSTITUTE FOR OCCUPATIONAL HEALTH
BENEFIT EXAMINATION ON DECEASED WORKER

Particulars of deceased:

Surname _____

Name _____ **Sex: Male/ Female**

Bureau No:		**Industry No:**	
Company No:		**Identity No:**	
Passport No:		**Pension Fund No:**	
Date of Birth			

Date of Death _____ **Age** _____
Date of last risk work _____
Date of last risk/benefit examination _____
Mine/works where last employed: _____
District & Country of origin _____
Place of death _____

Name and address of next of kin _____

Occupational Disease History

Was the deceased previously compensated? Yes/No If yes, state Bureau no. ☐

If yes, state the disease compensated for:

Date of compensation Day ☐ Month ☐ Year ☐

Smoker Yes / No
Ex-Smoker: Yes / No

Previous TB: Yes / No Did the deceased have TB when he died? Yes / No

Date of diagnosis of last episode of TB Day ☐ Month ☐ Year ☐

Chest X-rays submitted: ☐ **Yes** ☐ **No**

Evidence of pneumoconiosis at death: ☐ **Yes** ☐ **No** ☐ **Unknown**

If yes, specify _____

Lung function tests: FEV_1 _____ **Height of patient** _____
FVC _____

Date of Lung Function Test Day ☐ Month ☐ Year ☐

Clinical cause/causes of death

_____

_____

_____

_____

_____

Name of sender: _____

Address of sender: _____

Telephone No of sender: _____ **Fax No:** _____

SUMMARY OF COMPLETE LABOUR HISTORY:

NOTE: This summary should contain full details of the worker's service at all mines works and of other risk work both within the Republic and elsewhere, and where possible, exact dates should be stated.

Name and type of mine/works	Occupation	Date on which work started	Date on which work stopped	Service - Number of months

Number of years in mining _____

I certify that the above information is correct to the best of my knowledge

_____

Medical Officer/Examiner **Sign Name** **Print Name**

Date: