employment & labour

Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

Compensation Fund, Delta Heights Building 167 Thabo Sehume Street, Pretoria 0001
Tel: 0860 105 350 | Email address: covid19claims@labour.gov.za www.labour.gov.za

COVID-19 EXPOSURE AND MEDICAL QUESTIONNAIRE
(To be completed by employer)

EMPLOYEE DETAILS		
Name		Surname
ID Number		Nationality
Contact Number		Email
Occupation		
Next of Kin	Contact Number	

EMPLOYER DETAILS										
Name of Employer										
Industry/Sector	Province	GP	NW	LP	MP	FS	KZN	NC	EC	WC
Contact person	Responsibility									
Contact Number	Email									

EXPOSURE HISTORY										
Has the Employee travelled to any high risk countries/areas? / If Yes,									Yes	No
Area Travelled To	Date Travelled	D	D	M	M	Y	Y	Y	Y	
Length of Stay	Reason for Travel									
If No, has the employee been exposed to a confirmed occupationally-exposed case in the workplace If Yes,									Yes	No
Date of Contact	Contact Reported?								Yes	No

Period of Exposure	D	D	M	M	Y	Y	Y	Y	Total Confirmed Cases in Workplace
Cases on quarantine in area of work									

State the periods the employee was off-duty or performing light duty	From (DD/MM/YYYY)	To (DD/MM/YYYY)	Advances/Salary paid during these periods
Periods Off-duty			
Periods Performing Light Duty			

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MEDICAL HISTORY							
Does the employee suffer from any pre-existing medical conditions?						Yes	No
Has the employee been diagnosed with any other occupational disease?						Yes	No
If Yes to any of the above, please check all that apply or specify in the box below:							
Medical Condition							
	Pregnancy (trimester: ____________)		Post-partum (< 6 weeks)				
	Cardiovascular disease, including hypertension		Immunodeficiency, including HIV				
	Diabetes		Renal disease				
	Liver disease		Chronic lung disease				
	Chronic neurological or neuromuscular disease		Malignancy				
	Other(s), please specify:						
Medical Condition			**Year of Diagnosis**			**On Treatment?**	
Pre-existing conditions:			Y	Y	Y Y	Yes	No
Occupational diseases:			Y	Y	Y Y	Yes	No

Name	Signature	Date							
		D	D	M	M	Y	Y	Y	Y

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