Fall Protection Plan

Annexure 3

Annexure 3

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

Medical Certificate of Fitness

Name of Employee_____ ID Number_____ Co Number_____

*** Occupation** e.g General worker, Welder, Bricklayer, Steel fixer, Mobile crane operator, etc	*** Possible Exposure** e.g Noise, Heat, Fall risk, Confined spaces, etc	*** Job Specific Requirements** e.g Operating mobile crane, Digging trenches, Erecting formwork and support work etc	*** Protective Clothing** e.g Dust respirator, Welding gloves, etc

*** 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 abovementioned employee is fit to perform the duties as described by the employer in the matrix above.

Occupational Medicine Practitioner / Occupational Health Nursing Practitioner: _____

Signature_____ Practice Number_____ Date_____

Address_____

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