the dme
Department:
Minerals and Energy
REPUBLIC OF SOUTH AFRICA

SECTION 20 APPEAL
(IN TERMS OF MINE HEALTH AND SAFETY ACT, ACT NO. 29 OF 1996)

INSTRUCTIONS:

1. **Please return the completed form to: The Medical Inspector, Private Bag X59, Pretoria, 0001**
   Tel: (012) 317 8459/ 437 , Fax: (012) 320 1307
2. Only the Employee is allowed to sign this Appeal
3. Please attach relevant medical records and/ or letters from Occupational Medical Practitioner explaining the reason for medical incapacitation

A. PARTICULARS OF MINE

1 Registered name of mine _____

2 Company no _____ 3 Region _____

4 Description of mine (U/G; Surface; Quarry etc.) _____

5 Commodity or commodities being mined _____

6 Postal address _____

7 Tel no | | | | | | | | | | | 8 Fax no | | | | | | | | | | |

B. PARTICULARS OF EMPLOYEE

1 Surname and initials of employee _____

2 Identity no or Passport no | | | | | | | | | | | | | | |

3 Postal or residential address _____

4 Tel no | | | | | | | | | |

C. PARTICULARS OF EMPLOYEE REPRESENTATIVE

1 Employee representative's surname and initials _____

2 Tel no | | | | | | | | | | | 3 Fax no | | | | | | | | | | |

4 Postal address _____

D. PARTICULARS OF OCCUPATIONAL MEDICAL PRACTITIONER

1 Surname and initials of Occupational Medical Practitioner _____

2 Date of Incapacitation | d | d | m | m | y | y | y | y |

3 Postal address of Occupational Health Centre _____

4 Tel No | | | | | | | | | | | 5 Fax No | | | | | | | | | | |

E. OTHER INFORMATION REQUIRED

1 Date advised to obtain second medical opinion | d | d | m | m | y | y | y | y |

2 Who provided advice? Occupational Medical Practitioner ☐ Employee Representative ☐
Other (specify) ☐

3 Stipulate reason(s) for Appeal (No compensation matters should be mentioned)

I hereby give my consent to the Medical Inspector to review my medical records at the company I'm (currently) employed (at). I comprehend that I **may** be expected to undergo further medical examinations by a Medical Practitioner nominated by the Medical Inspector. I also comprehend that these medical examinations will have no cost implications to myself and I undertake to attend them should they be required at a time and place selected (to be determined).

_____ _____

SIGNATURE OF EMPLOYEE DATE