

CERTIFICATE OF FITNESS

Dr. MJ Mphuthi / Practice No: 0404160 / Sr. Sibongile Mahlangu / Practice No: 999 088 0000 8177 91
certify that the following employee:

Initials & Surname: AW. OUFANT ID NO: 781220 5166 086

Company Name: EK MAINTENANCE

Date of Examination: 20. 01. 2025 Expiry Date: 20. 01. 2026

Job Title: FITTER

PRE-EMPLOYMENT	PERIODICAL	EXIT
	✓	

MEDICAL EXAMINATION CONDUCTED INCLUDES THE FOLLOWING TESTS

	Done	Results
BLOODS	✓	N/A
FAR, NEAR VISION	✓	20/20
SIDE & DEPTH	✓	NORMAL
NIGHT VISION	✓	20/20

	Done	Results
Hearing	✓	3.9
Working at Heights	✓	FIT
Lung Function		
X-Ray	✓	N/A
Drug Screen	✓	N/A

Referred or follow up actions:

Review Date:

Restrictions:

Heights	Dust Exposure	Motorized Equipment	Wear Hearing Protection
Confined Spaces	Chemical Exposure	Wear Spectacles	Remain on Treatment for Chronic Conditions

Medical Fitness Declaration

FIT	Fit with Restriction	Fit with Condition	Temporary Unfit	UNFIT
------------	----------------------	--------------------	-----------------	--------------

Comments: N/A

Dr MJ Mphuthi

Occupational Medicine Practitioner
BScMed, PDM, MPH (HIV/AIDS),
MBChB, DOMH & CIME

20-01-2025

Practice NO: 1522469 MP No: 0404160

Email: mandiajockey@f - 083 209 1098

STAMP

Occupational Health Practitioner / Occupational Medical Practitioner

Dr MJ Mphuthi / Practice No. 0404160

Sr. Sibongile Mahlangu

SANC No: 14262133; SASOHN No: AR 2136 / MBChB DOH

Practice Number: 999 088 0000 8177 91

SIGNATURE



OCCUPATIONAL HEALTH AND SAFETY ACT, 85 OF 1993

Medical Certificate of Fitness Annexure 3

Co Number: _____

ID Number: 781090 5166 086

Name of Employee: AN. OUFANT

*Occupation	*Possible Exposure	*Job Specific Requirements	*Protective Clothing
Fittec	Heat	General Electrical Installation	Eye Protection
	Noise	Operate Mobile Plant	Hearing Protection
	Dust	Material & Manual Handling	Hard hat
	Ergonomics	Clearing Sites	Hi-vest
	Insufficient Illumination	Erecting & Breaking down Scaffolding	Safety Shoes (steel tip)
	Confined Spaces	Loading & offloading Materials	Gloves
	Fall Risk	Pulling Cable	Dust Masks
	Interaction with Plant and Equipment	Digging Holes/Trenches	Safety Harness
	Working on Heights	Working with portable electrical tools	Any other as required.
		Digging Holes/Tunnels/Trenches/Shafte	
	Hand tools/Electrical Hand Tools	Working with Hand tools	
	Electrical Hazard	Working at Heights	
		Welding	
		Driving: Light Duty /Construction Vehicle	

*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 examining and testing, using the above criteria by the Employer, satisfied myself that the abovementioned Employee is **FIT** UNFIT to perform the duties as described by the Employer in the matrix above.

Occupational health Nurse Practitioner: Sr S.F MAHLANGU (OHNP) Practice No: 999 088 000 811 735 SANC Reg: 14262133

Signature: _____ Doctor Review: _____ Date: 30.01.2025
SASOHN-AR-2136
Tel: 011 892 0771





011 892 0771

BOKSBURG: 135 Leeuwpoot Street, Boksburg South

WITBANK: 1 Finch Street, Cnr Beatty Ave 013 656 0001
Vat: 4660266307 CC: 2014/135234/07

CONSENT TO RELEASE INFORMATION FORM - MEDICAL

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize my health care provider

to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: ALJEN

Address: 18 VALDEHALL STR EDEN PARK ALBERTON

Purpose: I authorize the release of my health information for the following specific purpose:

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.¹



Blue Collar
OCCUPATIONAL HEALTH

BOKSBURG: 135 Leeuwpoot Street, Boksburg South 011 892 0771
WITBANK: 1 Finch Street, Cnr Beatty Ave 013 656 0001
Vat: 4660266307 CC: 2014/135234/07

- ☐ Only the following records or types of health information:
-

Term: I understand that this Authorization will remain in effect:

- ☐ From the date of this Authorization until the 30 day of 01, 2025.
☐ Until the Provider fulfills this request.
☐ Until the following event occurs: _____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use

Signature
Witness

Date

Signature of

If Individual is unable to sign this Authorization, please complete the information below:

REZONA

Name of Guardian/

Legal Relationship

20/01/2025

Date

Witness

Audiometric Test Results

Company : FK MAINTENANCE 11-12-2023

Summary

Name : Aw Olifant Age : 46
 ID Number : 7812205166086
 Company : FK MAINTENANCE 11-12-2023
 Occupation : fitter
 Tested by : Clinic
 Date of Test: 2025-01-20 Time: 09:55 AM
 Audio Type: Screening
 Noise Exposure: 85 - 104 dB Exposure date: 2023-12-11

	PLH	BL/Shift
Current	3.9	0
Previous	1.7	
Curr. - Prev.	2.2	
Baseline	0	0

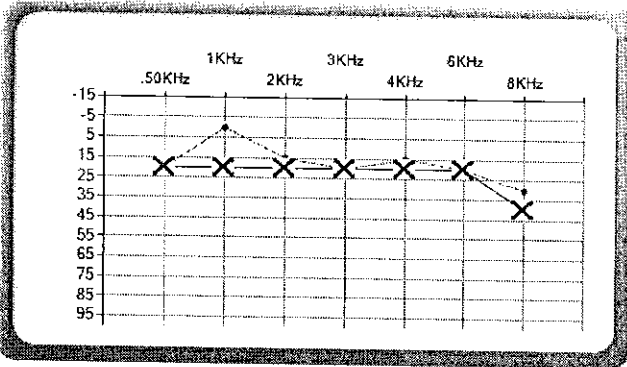
Date	Time	Consultation	Audio Type	LDSHL	RDSHL	PLH	SHB	SHPrv	PBI	ABHL	CAT	RTS	
2023-12-11	09:42 AM	Annual Med.	Initial	55	45	1.4	0	2.2	0	12.5	3C	30	1
2025-01-20	09:55 AM	Annual Med.	Screening	80	100	3.9	0	2.2	0	22.5	3C	55	2

Otoscopic Report

Left Ear : Clear
 Right Ear : Clear
 Comments:

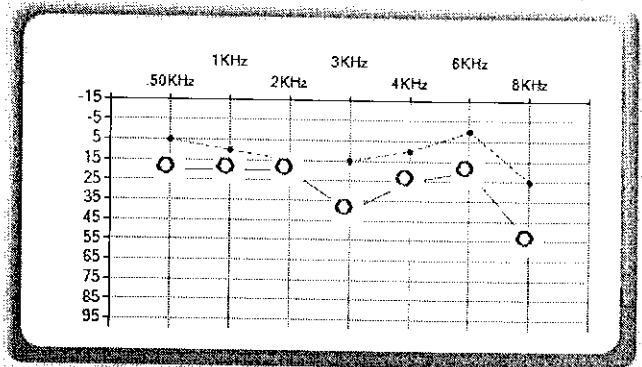
Left Ear

L500	L1000	L2000	L3000	L4000	L6000	L8000	STS	Avg.	
20	0	15	20	15	20	30		16.67	(1)
20	20	20	20	20	20	40	0	20	(2)
									(3)



Right Ear

R500	R1000	R2000	R3000	R4000	R6000	R8000	STS	Avg.	
5	10	15	15	10	0	25		13.33	(1)
20	20	20	40	25	20	55	0	28.33	(2)
									(3)



Notes :

I, the patient, hereby grant permission for the above information to be disclosed to my supervisor/manager/company.

Patients signature:	
OHN / OHP :	
Date/Time printed:	2025-01-20 10:01 AM

Audiometer Details

Model : Oscilla SM930
 SerialNo : 15349
 Calibrated on : 2024-07-15
 Calibrated by : Charles Kemp

MSG Keystone VS-V GT Medical Record Form




For use with Model 1160
VS-V GT Medical Screeners

Name AL JEN Date 20/01/2025
Occupation FITTER Age 46

Does the examinee wear: Glasses ☐ or Contacts ☐ (If yes, how often?) Always ☐ Sometimes ☐

What kind of vision correction? Distance Only ☐ Reading ☐ Multifocals ☐

FAR POINT TESTS — SWITCH TO FAR ON HAND CONTROL

#	TEST DESCRIPTION AND KEY (Corresponds to Hand Control)	UNACCEPTABLE	MARGINAL	ACCEPTABLE	*)
1	RIGHT EYE: ACUITY A B C 1. 20 = 547638 25 = 428576 30 = 943852 2. 40 = 795823 50 = 357248 60 = 7236 3. 70 = 9574 100 = 92 200 = 5	20/70 = 9574 20/200 = 5 20/60 = 7236 20/100 = 92 20/50 = 357248	(One Miss Allowed Per Line) 20/40 = 795823	20/30 = 943852 20/25 = 428576 20/20 = 547638	
2	LEFT EYE: ACUITY A B C 1. 20 = 745932 25 = 578236 30 = 346752 2. 40 = 534268 50 = 752386 60 = 6254 3. 70 = 8453 100 = 85 200 = 3	20/70 = 8453 20/200 = 3 20/60 = 6254 20/100 = 85 20/50 = 752386	(One Miss Allowed Per Line) 20/40 = 534268	20/30 = 346752 20/25 = 578236 20/20 = 745932	
3	BOTH EYES: ACUITY A B C 1. 20 = 857432 25 = 674235 30 = 382457 2. 40 = 563472 50 = 859423 60 = 8927 3. 70 = 2978 100 = 43 200 = 9	20/70 = 2978 20/200 = 9 20/60 = 8927 20/100 = 43 20/50 = 859423	(One Miss Allowed Per Line) 20/40 = 563472	20/30 = 382457 20/25 = 674235 20/20 = 857432	
INTERMEDIATE POINT TEST — SWITCH TO INT 1  OR INT 2  ON HAND CONTROL					
3	BOTH EYES: ACUITY A B C 1. 20 = 857432 25 = 674235 30 = 382457 2. 40 = 563472 50 = 859423 60 = 8927 3. 70 = 2978 100 = 43 200 = 9	20/70 = 2978 20/200 = 9 20/60 = 8927 20/100 = 43 20/50 = 859423	(One Miss Allowed Per Line) 20/40 = 563472	20/30 = 382457 20/25 = 674235 20/20 = 857432	
FAR POINT TESTS — SWITCH TO FAR ON HAND CONTROL 					
4	COLOR Severe (Red/Green) 32 79 23	None or One Correct	Two Correct	Three Correct	
4	COLOR Mild (Blue/Violet) 92 56 63	None or One Correct	Two Correct	Three Correct	
4	HORIZONTAL FIELD TEST	<input checked="" type="checkbox"/> 85° <input checked="" type="checkbox"/> 70° <input checked="" type="checkbox"/> 55° <input checked="" type="checkbox"/> NASAL	<input checked="" type="checkbox"/> NASAL <input checked="" type="checkbox"/> 55° <input checked="" type="checkbox"/> 70° <input checked="" type="checkbox"/> 85°		
	VERTICAL FIELD TEST	<input checked="" type="checkbox"/> 35° L <input checked="" type="checkbox"/> 35° R	<input checked="" type="checkbox"/> 35° L <input checked="" type="checkbox"/> 35° R		
5	PHORIA (EYE COORDINATION) Red—Lateral	ESO 0 1 2 3 4 5 6 7 8 9 EXO	0 1 2 3 4 5 6 7 8 9		
5	Green - Vertical	RIGHT H. 0 1 2 3 4 5 6 7 8 9 LEFT H.	ORTHO		
6	STEREOPSIS	<input checked="" type="checkbox"/> Box 10 %, 592° <input checked="" type="checkbox"/> Heart 30 %, 208° <input checked="" type="checkbox"/> Cross 40 %, 74°	<input checked="" type="checkbox"/> Star 75 %, 45° <input checked="" type="checkbox"/> Cross 85 %, 32°		

Continued on reverse side



012 333 7709

info@medicalsolutions.co.za

265 Soutpansberg Road, Rietondale, Pretoria, South Africa, 0084




www.medicalsolutions.co.za

CALIBRATIONS • REPAIRS • SALES • SERVICES • SOFTWARE • SUPPLIES

M-G Keystone VS-V GT Medical Record Form

For use with Model 1160
VS-V GT Medical Screeners

#	TEST DESCRIPTION AND KEY	UNACCEPTABLE	MARGINAL	ACCEPTABLE	*)
7	CONTRAST SENSITIVITY A B C 1. 10% = 958 20% = 479 30% = 863 2. 40% = 347 50% = 563 60% = 534 3. 70% = 426 80% = 728 90% = 962	90% = 962 70% = 426 80% = 728 60% = 534	50% = 563	40% = 347 30% = 863 20% = 479 10% = 958	
8	GLARE RECOVERY ROW 1. 2 6 5 1 4 3 9 ROW 2. 8 2 9 4 6 3 5 ROW 3. 6 3 9 5 2 7 4	<input type="checkbox"/> Four or less correct 2 6 5 1 4 3 9 8 2 9 4 6 3 5 6 3 9 5 2 7 4	<input type="checkbox"/> Five correct 2 6 5 1 4 3 9 8 2 9 4 6 3 5 6 3 9 5 2 7 4	<input checked="" type="checkbox"/> Six or more correct 2 6 5 1 4 3 9 ✓ 8 2 9 4 6 3 5 ✓ 6 3 9 5 2 7 4 ✓	
NEAR POINT TESTS — SWITCH TO NEAR ON HAND CONTROL 					
1	RIGHT EYE: ACUITY A B C 1. 20 = 547638 25 = 428576 30 = 943852 2. 40 = 795823 50 = 357248 60 = 7236 3. 70 = 9574 100 = 92 200 = 5	20/70 = 9574 20/200 = 5 20/60 = 7236 20/100 = 92 20/50 = 357248	(One Miss Allowed Per Line) 20/40 = 795823	20/30 = 943852 20/25 = 428576 20/20 = 547638	
2	LEFT EYE: ACUITY A B C 1. 20 = 745932 25 = 578236 30 = 346752 2. 40 = 534268 50 = 752386 60 = 6254 3. 70 = 8453 100 = 85 200 = 3	20/70 = 8453 20/200 = 3 20/60 = 6254 20/100 = 85 20/50 = 752386	(One Miss Allowed Per Line) 20/40 = 534268	20/30 = 346752 20/25 = 578236 20/20 = 745932	
3	BOTH EYES: ACUITY A B C 1. 20 = 857432 25 = 674235 30 = 382457 2. 40 = 563472 50 = 859423 60 = 8927 3. 70 = 2978 100 = 43 200 = 9	20/70 = 2978 20/200 = 9 20/60 = 8927 20/100 = 43 20/50 = 859423	(One Miss Allowed Per Line) 20/40 = 563472	20/30 = 382457 20/25 = 674235 20/20 = 857432	

Comments:



 012 333 7709
 info@medicalsolutions.co.za  www.medicalsolutions.co.za
 265 Soutpansberg Road, Rietondale, Pretoria, South Africa, 0084

CALIBRATIONS • REPAIRS • SALES • SERVICES • SOFTWARE • SUPPLIES

Questionnaire	Audio	Spiro	Physical	Drug Screen	Vision
---------------	-------	-------	----------	-------------	--------



MEDICAL QUESTIONNAIRE

Company Name: 7K MAINTENANCE

Employee: ALJEN

PERSONAL HISTORY

Initials: AL Surname: OLIVANT

First names: ALJEN WESLEY

ID Number: 7816205166086

Date of birth: 78 Y Y 12 20 1978/12/20

Marital Status: Single ☐ Married ☐ Divorce ☒ Window/Widower ☐

Position: FITTER

Department:

Pre-Employment ☐ Baseline ☐ Transfer ☐ Periodical ☐ Exit ☐ Other Specify ☐

MEDICAL HISTORY

	YES	NO	HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
1. Heart disease or high blood pressure		<input checked="" type="checkbox"/>	22. Bleeding from the rectum		<input checked="" type="checkbox"/>
2. Epilepsy or convulsions		<input checked="" type="checkbox"/>	23. Kidney stones or blood in the urine (including Bilharzia)		<input checked="" type="checkbox"/>
3. Glaucoma or blindness		<input checked="" type="checkbox"/>	24. Sugar or protein in the urine		<input checked="" type="checkbox"/>
4. Family Mellitus (Sugar sickness)		<input checked="" type="checkbox"/>	25. Prostate/Gynaecological problems		<input checked="" type="checkbox"/>
5. Family deaths before 60 years of age		<input checked="" type="checkbox"/>	26. Any blood or thyroid disorder		<input checked="" type="checkbox"/>
HAVE YOU EVER BEEN:	YES	NO	27. Malignant tumours cancer or radiotherapy		<input checked="" type="checkbox"/>

Questionnaire	Audio	Spiro	Physical	Drug Screen	Vision
---------------	-------	-------	----------	-------------	--------

6.Refused live insurance		✓	28.Weight loss (without dieting)		✓
7.Refused a driving licence		✓	29.Sexually transmitted disease		✓
8.Admitted to hospital(for any reason)		✓	30.Other illness or injuries		✓
9.A smoker	✓		31.Allergies : Penicillin etc.		✓
HAVE YOU EVER HAD OR DO YOU NOW HAVE:			32.Back problems ,joint or bone disease		✓
10.Frequent or severe headaches		✓	33.Varicose veins, piles		✓
11.Dizziness or unsteadiness		✓	34.Skin disease		✓
12.Unconsciousness(for any reason)		✓	HAVE YOU EVER :		✓
13.Head injury or concussion		✓	36.Had any physical abnormalities		✓
14.Epilepsy or fits of any kind		✓	37.Had any surgical operations done		✓
15.Any other neurological disorder		✓	38.Abused alcohol		✓
16.Any mental/Psychological disorder including		✓	39.Abused drugs or substances		✓
17.Eye or vision trouble(except for glasses)		✓	40.Used any medication		✓
18.Hearing or speech disorders		✓	OCCUPATIONAL HISTORY:		
19.Hay fever or allergy		✓	41.Asbestos exposure		✓
20.Asthma or lung disease		✓	42.Mine or underground work		✓
21.Collapsed lung(pneumonia)		✓	43.Chemical exposure		✓

Comments on Abnormalities:

MEDICAL TREATMENT WITHIN THE LAST TWO (2) YEARS

DATE	NAME OF MEDICAL PRACTITIONER AND MEDICAL SPECIALIST	DIAGNOSIS/REASON FOR TREATMENT

GENERAL PRACTITIONER OF PREVIOUS TEN YEARS

	NAME OF MEDICAL PRACTITIONER	CONTACT DETAILS
1		
2		

Questionnaire	Audio	Spiro	Physical	Drug Screen	Vision
---------------	-------	-------	----------	-------------	--------

I hereby declare that the above information is correct and I have not provided any misleading information to the company Name &

Surname _____ Employee

Signature _____

MEDICAL EXAMINATION CONFIDENTIAL REPORT

Height 173.7 CM

Weight 68.4 Kg

BMI 22.5

Has the weight changed by more than 5kg in the past year?	YES			NO	
If so state a reason					

Pulse	Rate per min	84-
BP	Systolic	136
	Diastolic	78

Sat 5 96.

Patient position Left lateral

If BP > 140 /90, please repeat after 5 min

Systolic	
Diastolic	

Abnormal BP due to (Not responding to Treatment, Never diagnosed, Defaulted Treatment)

Other.....

Urinalysis: Are any of the following present in the urine?

Blood	Yes	<u>No</u>
Protein	<u>Yes</u>	No
Glucose	Yes	<u>No</u>

++

Random Glucose	mmol/L	5.2	Random cholesterol(in indicated)	mmol/L
----------------	--------	-----	----------------------------------	--------

Temp: 37.0 °C

Abnormal Glucose due to (Not responding to treatment, never diagnosed, defaulted treatment)

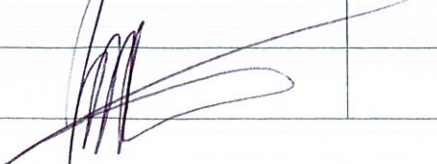
Questionnaire	Audio	Spiro	Physical	Drug Screen	Vision
---------------	-------	-------	----------	-------------	--------

.....

.....

.....

Vision	R	L	Contact lenses used		Audio	PLH	Spirometry		Chest X-rays	
Far	6/6	6/6	Yes	No <input checked="" type="checkbox"/>	Baseline	3.9	FVC 96	39		
Near	6/6	6/6	Yes	No <input checked="" type="checkbox"/>			FVC1	100		
							FVC1/FVC	85		

		Normal	Abnormal	Comments
1	Eyes , clinical abnormalities	<input checked="" type="checkbox"/>		
2	Ear ,Nose, Throat including defect of hearing	<input checked="" type="checkbox"/>		
3	Respiratory System	<input checked="" type="checkbox"/>		
4	Cardiovascular system including Heart size/sound	<input checked="" type="checkbox"/>		
5	Digestive System	<input checked="" type="checkbox"/>		
6	Nervous System	<input checked="" type="checkbox"/>		
7	Musculoskeletal System	<input checked="" type="checkbox"/>		
8	General	<input checked="" type="checkbox"/>		
	Lymphadenopathy: Inguinal, auxiliary, Cervical or			
	Any other circumstances associated with the health record or physical examination which is of importance and not recorded elsewhere in this report?			
RECOMMENDATION	Fitness status			
	Restrictions			
	Comments			
	Signature of Nurse			
	Signature of OHP			
	Signature OF OMP			

Questionnaire	Audio	Spiro	Physical	Drug Screen	Vision
---------------	-------	-------	----------	-------------	--------

WORKING AT HEIGHTS QUESTIONNAIRE

Name & Surname <i>ALJEN OLIVANT</i>			
	Main Complaint		
1.	Have you ever been advised NOT to work at height?	Yes	No
2.	Have you ever had a serious occupational accident or occupational diseases?	Yes	No
3.	Do you have a fear of heights or fear of enclosed spaces?	Yes	No
4.	Do you have, or have you ever had fits/seizures, epilepsy, blackouts, dizzy spells, or episodes of sudden weakness?	Yes	No
5.	Have you ever attempted to commit suicide or have suicidal thoughts?	Yes	No
6.	Have you ever seen a psychologist, psychiatrist or any other health professional for a mental health disease?	Yes	No
7.	Do you often have thoughts that are not own e.g. message from God, the devil or evil spirits?	Yes	No
8.	Do you have a substance abuse problem(alcohol/drugs)	Yes	No
9.	Are you aware of any other problems that could possibly affect your ability to safely perform expected duties and work at heights?	Yes	No
10.	Have you been informed of the tasks you are expected to perform, and the safety requirements and health requirements for working at heights?	Yes	No
11.	Do you have any chronic diseases e.g. diabetes or epilepsy	Yes	No
12.	Additional Comments:		
Examiner: I have explained to the employee that he should notify the supervisor if, at any time, he develops a health condition that he feels may affect his ability to work at height, including the use of medicine.		Yes	No
I <i>ALJEN</i>and ID NO <i>7812205166086</i> i hereby declare that all the Information furnished above is, to the best of my knowledge ,true and correct and that no information has been omitted or withheld.			

Health Practitioner's Comment: