FORM No.21

**WORKERS' COMPENSATION FUND CONTROL BOARD**
P.O BOX 71534 NDOLA
Email: compensation@workers.com.zm Phone: 02-610481/8 / Fax: 02-610487

**For official use only**

**Claim No.....**

# FINAL MEDICAL REPORT

(Section 91 of Act No. 10 of 1999)

| |
|---|
| **1 Full Name of Worker** |
| **2 Residential Address** |
| **3 Employer's Name** |
| **4 Employer's Address** |
| **5 DATE OF ATTENDANCE AT HOSPITAL**<br>**As IN – Patient: ……. As OUT-Patient: ……** |
| **6 DATE OF DISCHARGE FROM HOSPITAL**<br>**As In – Patient: …….. As Out –Patient: ……** |
| **7 Date able to resume work:** |
| **8 Full description of final Condition of injury and its effects on body function:** ……..<br>……<br>…… |
| **9 Has he/ she appeared before a Workers' Compensation Assessment Board? : ……**<br>**If so ,please attach a copy of Board's findings to the report** |
| **10. If he / she has not appeared before a Workers' Compensation Assessment Board , please state**<br>**Percentage of disablement in terms of the First Schedule (Section 69 refers):** ……**%** |
| **11 Remarks, if any** |

**I am satisfied that the period and nature of disablement set out above is entirely due to injury sustained and was not induced or prolonged by any other cause**

**Name of Medical Practitioner: ..... Signature: .....**

**Address: ..... Date: .....**

OFFICIAL STAMP