Private Bag X14, Highveld Park, 0169

administered by Sanlam

**APPLICATION FOR ILL HEALTH RETIREMENT IN TERMS OF THE MUNICIPALITY GRATUITY FUND SECTION 35**

**A**

# MEDICAL INVESTIGATION EMPLOYEE QUESTIONNAIRE

| | |
|---|---|
| **Date** | |
| **Name and surname** | |
| **Identity Number** | |
| **Employee Number** | |
| **Employer** | |
| **Branch** | |
| **CONTACT DETAILS** | |
| **Physical Address** | |
| **Postal Address** | |
| **Cell Phone Number** | |
| **Telephone Number** | |
| **SKILLS AND QUALIFICATIONS** | |
| **Highest School Qualifications** | |
| **Highest Qualification Achieved** | |
| **Years Service** | |
| **Medical Aid** | |
| **Medical Aid Number** | |

**Kindly answer the following questions fully, using the reverse side if necessary.**

| 1. | **Job Title** | |
|---|---|---|

2. **<u>Under which classification would you categorise your job?</u>**

| **Job Classification** | **Percentage Job Requirements per Day** | **Tick Where Applicable** |
|---|---|---|
| Very light work | • 80 – 100% Office bound<br>• No physical demands | |
| Light work | • 60 – 80% Office bound<br>• May work outside or in other places<br>• No or minimal physical demands | |
| Medium work | • 40 – 60% Office bound and rest of the time may include one or more of physical demands listed in the table below | |
| Heavy work | • 20 – 40% Office bound<br>• 60 – 80% Physical demands [see listed in the table below] | |
| Very heavy work | • 0 – 20% Office bound<br>• 80 – 100% Physical demands [see listed in the table below] | |

| **Physical Demands** | **Tick Where Applicable** |
|---|---|
| Heavy lifting | |
| Walking over uneven ground | |
| Squatting | |
| Kneeling | |
| Crouching | |
| Climbing | |
| Any other activities involving comparable physical effort | |

| 3. **Essential tasks**<br>Specific tasks that must be done by yourself and cannot be adjusted or re-allocated to other employees | **Time spent on task** | | |
|---|---|---|---|
| | Every shift | Once a week but essential | Seldom but essential |
| | Every shift | Once a week but essential | Seldom but essential |
| | Every shift | Once a week but essential | Seldom but essential |
| | Every shift | Once a week but essential | Seldom but essential |
| | Every shift | Once a week but essential | Seldom but essential |

| 4. **Environmental Condition Factor** | | | | |
|---|---|---|---|---|
| **Environmental Condition** | **Not present** Exposure does not exist | **Occasional** Exposure exists up to 1/3 of time | **Frequently** Exposure exists 1/3 to 2/3 of time | **Constantly** Exposure exists 2/3 or more of time |
| Exposure to weather | | | | |
| Extreme cold | | | | |
| Extreme heat | | | | |
| Wet and/or humid | | | | |
| Noise | | | | |
| Vibration | | | | |
| Proximity to moving mechanical parts | | | | |
| Exposure to electrical shock | | | | |
| Working in high places | | | | |
| Exposure to radiation | | | | |
| Working with explosives | | | | |
| Toxic or caustic chemicals | | | | |
| Confined spaces | | | | |

| 5. **Time spent during a normal work day [Walking + Standing + Sitting = 100% of one shift]:** | |
|---|---|
| ➢ Walking | % of shift |
| ➢ Standing | % of shift |
| ➢ Sitting | % of shift |
| **TOTAL** | **100% of shift** |

| 6. **Describe Health and Safety risks associated with this job:** | |
|---|---|
| Physical [Noise, radiation] | |
| Ergonomic [Working posture, repetitive movements] | |
| Chemical [Hazardous chemical substances, vapours] | |
| Psychological [Extraordinary stress] | |

| 7. **Which of your tasks are you UNABLE to perform? If not, why not?** |
|---|
| |
| |
| |

| 8. **What was the date you were last actively at work?** | | | |
|---|---|---|---|
| Normal Job | | Adjusted work | |

| 9. **Disease or injuries that lead to this investigation.** |
|---|
| |
| |
| |

| 10. **Have your services ever been terminated or a medical disability claim lodged as a result of a medical condition? If yes, describe.** | |
|---|---|
| Yes | |
| No | |

| 11. **Please give us the following details of medical practitioners who examined you / treated you for the condition:** | | | |
|---|---|---|---|
| | Name of doctor | Address | Telephone number |
| Usual family doctor | | | |
| Other medical practitioners | | | |
| Specialists | | | |
| Physiotherapists | | | |
| Occupational Therapists | | | |

| 12. **Are you presently undergoing medical treatment?** | |
|---|---|
| Yes | |
| No | |
| Specify illness and treatment: | |
| | |
| | |
| | |
| | |

| 13. **Are you presently performing normal / adjusted work?** | |
|---|---|
| Yes | |
| No | |

| 14. **When do you expect to be able to resume your work:** | | |
|---|---|---|
| ➢ Part-time and to what extent? | Date | |
| ➢ Full-time? | Date | |

| 15. **If not capable to do your own work, what other occupations do you consider yourself capable of performing:**<br>15.1 Within your own company by reason of your training, education, experience and competence?<br>15.2 In the open labour market, taking into account your training, education, experience and competence? |
|---|
| |
| |
| |
| |

| 16. **In your opinion, has the employer made adequate attempts to accommodate you in an adjusted / alternative position? If yes, give details; if no, why are you of this opinion?** | |
|---|---|
| Yes | |
| No | |
| Details | |
| | |
| | |

# WORK ABILITY QUESTIONNAIRE

Job Classification

| | |
|---|---|
| Mainly manual work | |
| Roughly 50/50 manual and intellectual work | |
| Mainly intellectual work | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **1.** | **Current work ability compared with the lifetime best** | | | | | | | | | |
| | Assume that your work ability at its best has a value of 10 points. How many points would you give your current work ability?<br>[0 = cannot work at all; 10 = the same as lifetime best ability to perform current work] | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

| | | |
|---|---|---|
| **2a.** | **Work ability in relation to the demands of the job** | |
| | How do you rate your current work ability with respect to the physical demands of your work? | |
| | Very good | 5 |
| | Rather good | 4 |
| | Moderate | 3 |
| | Rather poor | 2 |
| | Very poor | 1 |
| **2b.** | How do you rate your current work ability with respect to the **mental** demands of your work? | |
| | Very good | 5 |
| | Rather good | 4 |
| | Moderate | 3 |
| | Rather poor | 2 |
| | Very poor | 1 |

| | | | |
|---|---|---|---|
| **3.** | **Current Diseases** | | |
| | In the following list, mark your injuries or illness. Also indicate **whether a physician has diagnosed** your illness or whether it is your own assessment / diagnosis. | | |
| | **CANCER** | *YES* | *NO* |
| | Disease: | *Physician's diagnosis* | *Own diagnosis* |
| | | | |
| | **HEART OR BLOOD VESSEL DISEASE** | *YES* | *NO* |
| | Disease: | *Physician's diagnosis* | *Own diagnosis* |
| | | | |
| | **BRAIN, NERVE OR MUSCLE DISEASE** | *YES* | *NO* |
| | Disease: | *Physician's diagnosis* | *Own diagnosis* |
| | | | |
| | **LUNG DISEASE** | *YES* | *NO* |
| | Disease: | *Physician's diagnosis* | *Own diagnosis* |
| | | | |
| | **JOINT OR SPINAL DISEASE** | *YES* | *NO* |
| | Disease: | *Physician's diagnosis* | *Own diagnosis* |
| | | | |
| | **BLOOD OR BONE MARROW DISEASE** | *YES* | *NO* |
| | Disease: | *Physician's diagnosis* | *Own diagnosis* |
| | | | |
| | **ABDOMINAL OR LIVER DISEASE** | *YES* | *NO* |
| | Disease: | *Physician's diagnosis* | *Own diagnosis* |

| | | | |
|---|---|---|---|
| | **KIDNEY, BLADDER OR PROSTATE DISEASE** | *YES* | *NO* |
| | Disease: | *Physician's diagnosis* | *Own diagnosis* |
| | | | |
| | **PSYCHIATRIC DISEASE** | *YES* | *NO* |
| | Disease: | *Physician's diagnosis* | *Own diagnosis* |
| | | | |
| | **METABOLIC DISEASE [i.e. Diabetes, Thyroid, etc.]** | *YES* | *NO* |
| | Disease: | *Physician's diagnosis* | *Own diagnosis* |
| | | | |
| | **EAR, NOSE & THROAT DISEASE** | *YES* | *NO* |
| | Disease: | *Physician's diagnosis* | *Own diagnosis* |
| | | | |
| | **SKIN DISEASE** | *YES* | *NO* |
| | Disease: | *Physician's diagnosis* | *Own diagnosis* |
| | | | |
| | **INJURIES** | *YES* | *NO* |
| | Injury: | *Physician's diagnosis* | *Own diagnosis* |
| | | | |
| | | | |
| | | | |
| | **OTHER DISEASES OF NOTE** | *YES* | *NO* |
| | Disease: | *Physician's diagnosis* | *Own diagnosis* |
| | | | |
| | | | |

| **4.** | **Estimated work impairment due to diseases** | |
|---|---|---|
| | Is your illness or injury a hindrance to your current job? | |
| | There is no hindrance / I have no diseases | |
| | I am able to do my job, but it causes some symptoms | |
| | I must **sometimes** slow down my work pace or change my work methods | |
| | I must **often** slow down my work pace or change my work methods | |
| | Because of my disease, I feel I am able to do only part-time work | |
| | In my opinion, I am entirely unable to work | |

| **5.** | **Sick leave during the past year [12 months]** | |
|---|---|---|
| | None at all | |
| | At the most 9 days | |
| | 10 – 24 days | |
| | 25 – 99 days | |
| | 100 – 365 days | |
| **6.** | **Own prognosis of work ability two years from now** | |
| | Do you believe that, from the standpoint of your health, you will be able to do your current job **two years from now**? | |
| | Unlikely | |
| | Not certain | |
| | Relatively certain | |

| 7. | **Mental resources** | |
|---|---|---|
| a. | Have you recently been able to enjoy your regular daily activities? | |
| | Often | |
| | Rather often | |
| | Sometimes | |
| | Rather seldom | |
| | Never | |
| b. | Have you recently been active and alert? | |
| | Often | |
| | Rather often | |
| | Sometimes | |
| | Rather seldom | |
| | Never | |
| c. | Have you recently felt yourself to be full of hope for the future? | |
| | Continuously | |
| | Rather often | |
| | Sometimes | |
| | Rather seldom | |
| | Never | |

## DECLARATION

I solemnly and sincerely declare that the particulars given above, to the best of my knowledge and belief, true and correct.

| | |
|---|---|
| Signature of Employee | |
| Date | |

## Consent for Disclosure of Confidential Information

I _____ Employee number _____ hereby grant my voluntary and informed consent to medical practitioners to disclose my medical and personnel records to the Medical Practitioners appointed by my employer to assess my medical incapacity.

I am also aware the all the medical information may be submitted to the responsible person appointed by my employer for making a final decision about my capacity to continue in my existing job.

This also includes my previous medical treatment as well as any psychological or psychiatric records, for the purpose of determining my ability to perform my work.

**Thus done and signed at …… on this ……. day of …… 20__ .**

Signature: ……

Full names and surname: ……

Identity number: ……

Date: ……

## MEMBER'S DECLARATION

**PLEASE READ AND UNDERSTAND THE FOLLOWINNG DECLARATION CAREFULLY, BEFORE SIGNING AT THE PLACE PROVIDED FOR YOUR SIGNATURE**

| | | |
|---|---|---|
| 1. | I acknowledge and understand that my duty to disclose all relevant information includes the disclosure of all and any information pertaining to my health and previous medical history to enable my application for ill health retirement to be properly assessed. | **Initials** |
| 2. | I declare and undertake that all the information and details I will furnish to my employer or any examining medical doctor/practitioner/specialist in supporting my application for ill health retirement will be true and accurate to the best of my knowledge. I declare and undertake that no medical or other information, which would reasonably be required by my employer or the MGF to consider and assess my application for ill health retirement, will be deliberately withheld, omitted or concealed. | **Initials** |
| 3. | I am aware that the false, inaccurate or incomplete information and/or detail supplied in support of my application for ill health retirement may in appropriate circumstances constitute fraud and the MGF reserves it's rights in terms thereof. | **Initials** |
| 4. | I hereby authorise the MGF, its employees and its Claims Assessor irrevocably to obtain any information that they, in their sole discretion might consider necessary in respect of my health and employment circumstances from any person who has such information available and I hereby indemnify anybody who, at the request of the above-mentioned supplies information, against any legal action whatsoever as a result of them supplying the information. I undertake to sign the necessary consents in this regard if required to do so. | **Initials** |
| 5. | I agree and consent to any necessary or appropriate medical or other investigations concerning the medical information or details and employment circumstances I will provide, or have already provided or which may be or become required. I am aware that the MGF, its employees or its Claims Assessor may require medical practitioners/specialists to undertake full medical examinations of me, and I confirm my willingness to co-operate and participate in any medical or related examinations which may be considered necessary. | **Initials** |
| 6. | I am aware that I am responsible for the payment of all medical costs relating to my disability assessment. This includes payment of the disability assessment conducted by Alexander Forbes Health Solutions and all costs relating to any additional/further medical test(s), examination(s) and/or investigation(s) which they may require to enable them to properly assess my application for Ill Health Retirement. I am aware of the fact that an amount equal to the agreed fee between the MGF and the claims assessor must accompany my application, when it is referred to the MGF Administrator and that should I fail to enclose the said amount in my application, my application will not be assessed. | **Initials** |
| 7. | I hereby authorise, consent to and instruct any doctor/hospital/clinic/institution/ specialist/similar person/body, which is presently or may be in possession of (or may in future come into possession of) any information or knowledge concerning my past, present or future state of health, to disclose and make these available to my employer or the MGF, its employees or its Claim Assessor. I further declare that this authorisation, consent and instruction must remain valid before, as well as after, my death, should this occur. | **Initials** |

| | | |
|---|---|---|
| 8. | I hereby indemnify my employer, the MGF, its employees, its claims assessor and any medical officer designated by them for medical examination purposes, against any claims flowing forth from any such medical examinations, reports and recommendations and the consequences thereof. | **Initials** |
| 9. | I hereby declare that I am not currently receiving any Ill Health retirement benefit from any institution. I further declare that my service has not previously been terminated with any other employer for any reason relating to my poor/ill health. | **Initials** |
| 10. | I hereby declare that I am satisfied that my employer has done everything that is reasonable to accommodate my medical impairment in their workplace, and that it has not been successful. | **Initials** |

**SIGNED ON THIS** _____ **DAY OF** _____

**AT** _____

_____ _____

**SIGNATURE** **DATE**

**WITNESSES** **1.** _____

**2.** _____

MUNICIPAL GRATUITY FUND

administered by Sanlam

Private Bag X14, Highveld Park, 0169

**APPLICATION FOR ILL HEALTH RETIREMENT IN TERMS OF THE MUNICIPALITY GRATUITY FUND SECTION 35**

**B**

# EMPLOYER DECLARATION IN RESPECT OF A MEDICAL INVESTIGATION

## EMPLOYEE DETAILS

| | |
|---|---|
| Full Name of Employee | |
| Employee Number | |
| Job Title [Current] | |
| ID Number | |
| Telephone Number | |
| Current Educational Level | |
| Other Courses Done | |

## EMPLOYER DETAILS

| | |
|---|---|
| Name of Employer | |
| Address | |
| Telephone Number | |
| Fax Number | |
| Contact Person | |

## REASON FOR REFERRAL / APPLICATION

| | |
|---|---|
| Permanent Disability Assessment<br>*[I.e. services of employee to be terminated; application for disability benefits from a Policy / Pension Fund]* | |
| Work Capacity Investigation<br>*[I.e. services of employee not terminated yet, but assessment for fitness for work for own / alternative job for accommodation purposes]* | |
| Other | |

## EMPLOYEE ATTENDANCE DETAILS

| | | |
|---|---|---|
| Date commenced employment with this company | | |
| Last active day at work to all normal duties in current job | | |
| Was the employee in full-time and normal employment on the last day at work? | | |
| Date the employee returned to normal / adapted work? [If applicable] | | |
| Date when employee will become unpaid | | |
| Amount of sick leave days used in last 24 months | | |
| Balance sick leave available | Date | |
| | Days | |

## GENERAL

| Which aspects of his/her most recent job is the employee currently unable to do? |
|---|
| |
| |
| |
| |
| |
| |
| |
| |

# OCCUPATIONAL REQUIREMENTS OF JOB TO BE ASSESSED

| | |
|---|---|
| **Previous Job Title** | |
| **Present Job Title** | |
| **For which job must this person be assessed?** | |

| **Job Type [Job to be assessed]** | |
|---|---|
| **Job Type** | **Tick where applicable** |
| Managerial; Supervision | |
| Professional; Technical; Clerical | |
| Hand Intensive | |
| Machine Operators | |
| Cleaners; Attendants | |
| Drivers | |
| Labourers; Material Handlers | |
| Mechanics; Installers; Repairers; Servicers | |
| Construction Workers | |
| Miscellaneous | |

**Under which classification would you categorise the job?**

| Job Classification | Percentage Job Requirements per Day | Tick Where Applicable |
|---|---|---|
| Very light work | • 80 – 100% Office bound<br>• No physical demands | |
| Light work | • 60 – 80% Office bound<br>• May work outside or in other places<br>• No or minimal physical demands | |
| Medium work | • 40 – 60% Office bound and rest of the time may include one or more of physical demands listed in the table below | |
| Heavy work | • 20 – 40% Office bound<br>• 60 – 80% Physical demands [see listed in the table below] | |
| Very heavy work | • 0 – 20% Office bound<br>• 80 – 100% Physical demands [see listed in the table below] | |

| Physical Demands | Tick Where Applicable to this Employee |
|---|---|
| Heavy lifting | |
| Walking over uneven ground | |
| Squatting | |
| Kneeling | |
| Crouching | |
| Climbing | |
| Any other activities involving comparable physical effort | |

| **Essential tasks**<br>Specific tasks that must be done by him/herself and cannot be adjusted or re-allocated to other employees | **Time spent on task** | | |
|---|---|---|---|
| | Every shift | Once a week but essential | Seldom but essential |
| | Every shift | Once a week but essential | Seldom but essential |
| | Every shift | Once a week but essential | Seldom but essential |
| | Every shift | Once a week but essential | Seldom but essential |
| | Every shift | Once a week but essential | Seldom but essential |
| | Every shift | Once a week but essential | Seldom but essential |

| **Environmental Condition Factor**<br>**[To which employee is exposed to on a daily basis when performing his duties]** | | | | |
|---|---|---|---|---|
| **Environmental Condition** | **Not present** Exposure does not exist | **Occasional** Exposure exists up to 1/3 of time | **Frequently** Exposure exists 1/3 to 2/3 of time | **Constantly** Exposure exists 2/3 or more of time |
| Exposure to weather | | | | |
| Extreme cold | | | | |
| Extreme heat | | | | |
| Wet and/or humid | | | | |
| Noise | | | | |
| Vibration | | | | |
| Proximity to moving mechanical parts | | | | |
| Exposure to potential electrical shock | | | | |
| Working in high places | | | | |
| Exposure to radiation | | | | |
| Working with explosives | | | | |
| Toxic or caustic chemicals | | | | |
| Confined spaces | | | | |

| **Time spent during a normal work day [Walking + Standing + Sitting = 100% of one shift]:** | |
|---|---|
| ➢ Walking | % of shift |
| ➢ Standing | % of shift |
| ➢ Sitting | % of shift |
| **TOTAL** | **100% of shift** |

**Describe Health and Safety risks associated with this job:**

| | |
|---|---|
| Physical [Noise, radiation] | |
| Ergonomic [Working posture, repetitive movements] | |
| Chemical [Hazardous chemical substances, vapours] | |
| Psychological [Extraordinary stress] | |

**Is this person responsible for any evacuation of people / emergency operations [i.e. fire fighting, first aid]?**

| | |
|---|---|
| **YES** | |
| **NO** | |
| If yes, give details | |

**Attempts to accommodate employee**

| |
|---|
| What efforts have you made to adapt the employee's work environment or duties to accommodate his/her impairment(s)? If no efforts at adaptations, please furnish reason. |
| |
| |
| |
| |
| What efforts have you made to accommodate the employee in an alternative position? If no efforts at accommodation, please furnish reason. |
| |
| |
| |
| |

**Please attach the following:**

- Certified copy of original identity document
- Fully completed job description form
- Sick leave records covering the past two years, with copies of any sick leave certificates [if available]

| Who does employee report to [if not same as signatory]? | |
|---|---|
| Name | |
| Title | |
| Contact details | |

## DECLARATION

| | |
|---|---|
| Name of Signatory | |
| Designation | |
| E-Mail Address | |
| Cell Phone Number | |
| Signature | |
| Date | |

MUNICIPAL GRATUITY FUND

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Private Bag X14, Highveld Park, 0169

**APPLICATION FOR ILL HEALTH RETIREMENT IN TERMS OF THE MUNICIPALITY GRATUITY FUND SECTION 35**

**C**

# MEDICAL EXAMINATION

## 1. EMPLOYEE INFORMATION

| | | | | | | |
|---|---|---|---|---|---|---|
| Name | | | | | | |
| Method of Identification | *ID Document* | | *Drivers Licence* | | *Other = specify* | |
| Employee Nr | | | | | | |
| Job Title | | | | | | |
| ID Number | | | | | | |
| Age | | | | | | |
| Contact Details | | | | | | |
| Consent for Disclosure signed? | Yes | | No | | | |

## 2. HISTORY

| **Narrative History**<br>**Chief complaints, history of injury or illness, occupational history, past medical history, family history, social history** |
|---|
| |
| **Main Complaints** |
| |
| |
| |
| |
| |
| |
| **Other Illness** |
| |
| |
| |
| |

## 3. MEDICAL EXAMINATION

| | | | | |
|---|---|---|---|---|
| **Cardiovascular System** | | | | |
| • *Height* | | | | |
| • *Weight* | | | | |
| • *Blood Pressure* | | | | |
| • *Pulse Rate* | */min* | *Regular* | *Irregular* | |
| • *Peripheral Oedema* | | | | |
| **Respiratory System** | | | | |
| • *Physical examination* | | | | |
| **Abdomen** | | | | |
| • *Physical examination* | | | | |
| **Upper Extremities** | | | | |
| • *General appearance* | *Left* | | *Right* | |
| • *Neurological* | *Left* | | *Right* | |
| • *Power* | *Left* | | *Right* | |
| • *Handgrip* | *Left* | | *Right* | |
| • *Reflexes* | *Left* | | *Right* | |
| • *ROM* | *Left* | | *Right* | |
| • *Dexterity* | *Left* | | *Right* | |
| *Description of abnormalities Upper Extremities* | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Lower Extremities** | | | | |
| • *General appearance* | *Left* | | *Right* | |
| • *Neurological* | *Left* | | *Right* | |
| • *Power* | *Left* | | *Right* | |
| • *Reflexes* | *Left* | | *Right* | |
| • *ROM* | *Left* | | *Right* | |
| *Description of abnormalities/ radiculopathy Lower Extremities* | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Hip Joints** | *Left* | | *Right* | |
| **Spine** | | | | |
| | | | | |
| | | | | |
| *Straight Leg Raising* | *Left* | | *Right* | |
| **Skin** | | | | |
| | | | | |
| **Ear, Nose and Throat** | | | | |
| | | | | |
| **Other Central Nervous System Pathology:** | | | | |
| | | | | |
| **Cognitive Performance:** | | | | |
| | | | | |

| |
|---|
| **Mood and behaviour:** |
| |

## 4. CAPACITY TO EXECUTE ACTIVITIES OF DAILY LIVING

Please tick where applicable

| **ACTIVITY** | **CURRENT LIMITATIONS** | | | | **EXPECTED FUTURE ABILITY** | | |
|---|---|---|---|---|---|---|---|
| | No limitations | Partial limitations | Impossible | Danger to self or others | Improve | Remain constant | Deteriorate |
| **Self-care, personal hygiene** *Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating* | | | | | | | |
| **Communication** *Writing, typing, seeing, hearing, speaking* | | | | | | | |
| **Physical activity** *Standing, sitting, reclining, walking, climbing stairs* | | | | | | | |
| **Sensory function** *Hearing, seeing, tactile feeling, tasting, smelling* | | | | | | | |
| **Non-specialised hand activities** *Grasping, lifting, tactile discrimination* | | | | | | | |
| **Travel** *Riding, driving, flying* | | | | | | | |

## 5. CAPACITY TO EXECUTE INSTRUMENTAL ACTIVITIES OF DAILY LIVING

| ACTIVITY | CURRENT LIMITATIONS | | | |
|---|---|---|---|---|
| | No limitations | Partial limitation | Impossible | Danger to self or others |
| **Care of others (including selecting and supervising caregivers)** | | | | |
| **Care of pets** | | | | |
| **Child rearing** | | | | |
| **Communication device use** | | | | |
| **Community mobility** | | | | |
| **Financial management** | | | | |
| **Health management and maintenance** | | | | |
| **Home establishment and maintenance** | | | | |
| **Meal preparation and cleanup** | | | | |
| **Safety procedures and emergency responses** | | | | |
| **Shopping** | | | | |

## 6. RECOMMENDATIONS ON FURTHER EXAMINATIONS OR DIAGNOSTIC STUDIES REQUIRED

| |
|---|
| |
| |
| |
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| Venue of Examination | |
| Name of Examiner | |
| Signature of Examiner | |
| Qualifications | |
| Date of Examination | |