Candidate ID Number													

Certificate / Confirmation of Disability Status

The completion of this form is solely for the purpose of verification by JOB-ABLED in terms of People with Disabilities to ensure the appropriate reasonable accommodation is provided and accurate statistics are reported on.

Only a medical practitioner or other appropriately qualified professional certified and licenced to practice in South Africa is authorised to certify this form by confirming the disability status of the applicant.

A. Candidate Consent:

I, hereby give consent to have my diagnosis/ condition disclosed to JOB-ABLED for the purpose of Disability Certification in terms of the Employment Equity Act of 1998.

Name of Candidate: _____

Surname of Candidate: _____

ID Number of Candidate: _____

Candidate Signature: _____

B. Information about Disability: (Tick and/ or fill in details)

Tick and describe below if necessary		
Visual Impairment	Partial Impairment	
	Blind	
Hearing Impairment	Partial Impairment	
	Deaf	
	Hearing Aid	
	Deaf-Blind	

	Description
Psychosocial Disability	
Physical Disability	
Assistive Devices	
Chronic Illness	

Duration of disability	Temporary	
	Permanent	

Neurodevelopmental	
Disability not mentioned	

Describe the nature of the disability and the support required:

C. Medical Practitioner / Occupational Health Practitioner's

I, _____, Medical Practitioner / Occupational Health Practitioner, certify that I have interviewed, examined and reviewed the relevant medical records of _____. I certify/confirm that he/she is disabled according to the criteria specified in the Employment Equity Act No 55 of 1998 and the Codes of Good Practice as amended on the Key Aspects of Disability in the Workplace which defines disability as follows: "people who have long term or recurring physical or mental impairment which substantially limits their prospects of entry into, or advancement in, employment".

Please turn over

Candidate ID Number

Medical Practitioner/Occupational Health Practitioner's

STAMP

Name: _____

HPCSA Number: _____

Practice Number: _____

Practice Contact Number: _____

Practice Adress: _____

_____

Date: _____

Signature: _____

** This form is not valid without the examining doctor's registration and practice number and the doctor, hospital or clinic stamp. **