REGULAR FORCE
MEDICAL CONTINUATION FUND

INJURY ON DUTY (IOD) CONFIRMATION FORM

Tel: 012 679 4201 | Email: preauth@rfmcf.co.za

VPA Membership Number:

Important Notice

Dear RFMCF Member,

An Injury on Duty (IOD) refers to any injury sustained while performing work-related activities during active service.

If you, or any of your registered dependants, have experienced an injury on duty (recently or in the past), it is essential that you report it to the Fund by completing this form, which outlines the details of the injury. Send the completed form to: **preauth@rfmcf.co.za**

Disclaimer: If you or your dependants have not experienced an injury on duty, please still submit the form, indicating that there was no injury. By signing the form and submitting the information you provided, you confirm that all details are accurate and truthful. Providing false or misleading information could result in adverse rulings, including the denial of claims or other repercussions.

Personal Details of the Patient

Name & Surname:

ID number:

Contact Number:

Email Address:

Injury on Duty Details

Date of Injury:

Location of Injury (place):

*MPO/CC Number:

Description of Injury (Type of Injury):

(Please specify nature of the injury, e.g., fracture, sprain, burn, etc., being specific of the body region that was affected by the IOD and whether permanent medical challenges resulted due to the IOD)

*If you reported your IOD during active service, the HR Division would have captured your injury and generated a MPO/CC number for future related healthcare treatment.

Past IOD-Related Healthcare Treatment

Specify Past Treatment Received (if applicable):
(e.g., surgeries, hospitalisations, medications)

Past Healthcare Provider who treated the IOD injury (if applicable):

Current IOD-Related Healthcare Treatment

Specify current Treatment Received (if applicable):
(e.g., physical therapy, ongoing medical care)

Current Healthcare Provider who treats the IOD injury (if applicable):

Current HCP Contact Number:

Current HCP Email Address:

Additional Information

Specify any additional information about the IOD that was not listed above:

Confirmation & Signature

By signing below, I confirm that the information provided in this report is accurate and truthful. I understand that providing false or incomplete information may result in adverse rulings or penalties.

Signature of Patient/Member:

Date: