

PART I CONFINED MEMBER'S NOTIFICATION (To be fill up by confined member)

NAME OF CONFINED MEMBER (PLEASE PRINT IN FULL)		SS NUMBER	TAX ACCOUNT NUMBER
ADDRESS OF EMPLOYER		RESIDENCE OF CONFINED MEMBER	
EMPLOYER'S REGISTERED NAME		EXACT DATE OF CONFINEMENT: PLACE/ADDRESS OF CONFINEMENT	

This is to notify my employer that I am currently confined. The name of my employer, the place/address and the date when such confinement started are indicated above. I certify that I am hereby waiving in favor of the SSS all information which my physician has acquired while attending to me as a patient in a professional capacity which information was necessary to enable him to act in that capacity. I hereby consent to the examination of my physician as to all information acquired by him from physical/mental examination of any person and all results of X-ray, laboratory, and/or special diagnostic examination. I further waive all information held privilege by law.

NAME AND SIGNATURE OF MEMBER'S AUTHORIZED REPRESENTATIVE (If sick member cannot write, print right thumbmark)	SIGNATURE OF CONFINED MEMBER	(RIGHT THUMBMARK)
(Please sign over your printed name)		

PART II MEDICAL CERTIFICATE (This block to be filled by attending physician)

I CERTIFY THAT I HAVE EXAMINED /ATTENDED the above-named employee and state the following:

EXACT DATE EXAMINED/ATTENDED	AGE	SEX	CIVIL STATUS	OCCUPATION	ADDRESS OF CONFINEMENT
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THIS IS BEING SUBMITTED AS: (Check applicable box and state corresponding report/findings)

an INITIAL CERTIFICATE
 CLINICAL SUMMARY (Please read accompanying instructions.)

an INTERMEDIATE a FINAL CERTIFICATE
 PROLONGED CONFINEMENT DUE TO :

DIAGNOSIS

IN MY MEDICAL OPINION the confinement including the convalescing or recuperation period may last for _____ days. FIT TO RESUME WORK ON _____ (estimated date)

(a) FINAL DIAGNOSIS (Give progress report of patient)

NO. OF DAYS CONFINEMENT EXTENSION EFFECTIVE (Exact Date)

Confinement VERIFIED by employer/company physician

Confinement NOT VERIFIED by employer/company physician

CONFINED AT
WILL BE FIT TO RESUME WORK ON (Exact Date)
PRINTED NAME & SIGNATURE OF EMPLOYER/ATTENDING PHYSICIAN

PRINTED NAME & SIGNATURE OF ATTENDING PHYSICIAN	
ADDRESS OF PHYSICIAN	ADDRESS OF PHYSICIAN
REGISTRATION/LICENSE NO.	REGISTRATION/LICENSE NO.

PART III EMPLOYER'S REPORT (This block to be filled up by Employer)

NAME OF CONFINED MEMBER		OCCUPATION (Exact description of work)
TIME OF WORK (Inclusive hours)	HOW LONG EMPLOYED?	Date of Employment
CAUSE OF INJURY		DESCRIBE FULLY HOW ACCIDENT HAPPENED AND STATE WHAT EMPLOYEE WAS DOING WHEN INJURED.
(a) Machines or tool _____		
(b) Kind of power (Hand, foot, electrical steam, etc.) _____		
(c) Part of Machine on which accident occurred. _____		
(d) Was he injured during his regular occupation? _____		Time, date & place of accident:

EMPLOYER'S/COMPANY'S ACKNOWLEDGEMENT RECEIPT (FROM SSS)		EMPLOYEE'S ACKNOWLEDGEMENT RECEIPT (FROM COMPANY)	
NAME OF CONFINED MEMBER		NAME OF CONFINED MEMBER	
EMPLOYER		ADDRESS	
ADDRESS		EMPLOYER	
CONFINEMENT PERIOD (Exact date)		START OF CONFINEMENT (Exact Date)	
FROM	TO		
RECEIVED BY	DATE RECEIVED	NOTIFICATION RECEIVED BY	DATE RECEIVED

CERTIFICATION BY EMPLOYER

START OF CONFINEMENT (Exact Date)	SICKNESS NOTIFICATION WAS RECEIVED BY US ON _____ 19____ thru: Mail/phone	SICKNESS OCCURRED WHILE (working, on leave, etc.)
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COMPANY HAS NO WAY OF VERIFYING THE SICKNESS BECAUSE: (Check applicable box)

He/she notified us only upon returning to work on _____
 Company has no physician
 The place of confinement was in _____ which is _____ kms. away

NATURE OF BUSINESS	NO. OF EMPLOYEES EMPLOYED	COMPANY ID NUMBER	PRINTED NAME & SIGNATURE OF COMPANY EXECUTIVE
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FOR SSS USE ONLY	
MEDICAL EVALUATION	
FINAL DIAGNOSIS	<input type="checkbox"/> APPROVED: _____ days, from _____ to _____ <input type="checkbox"/> REDUCED: _____ days, from _____ to _____ <input type="checkbox"/> DENIED: _____ <input type="checkbox"/> CLAIMANT TO COME FOR PHYSICAL EXAMINATION, CHEST X-ray. Submit: _____ Returned: _____
PREVIOUSLY APPROVED CONFINEMENT PERIOD: From _____ (Exact Date)	to _____ (No. of Days)

SIGNATURE OF SSS MEDICAL EXAMINER/RETAINER PHYSICIAN	DATE EVALUATED
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RECONSIDERATION/EXTENSION:	NO. OF DAYS	FROM	TO	MEDICAL EXAMINER	DATE
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IMPORTANT INSTRUCTIONS

1. The employee shall notify his employer of his sickness or injury within five (5) calendar days after the start of his confinement. Within five (5) days from receipt of notice or knowledge of the sickness or injury, the employer shall record in his logbook the facts thereof and within five (5) days thereafter the employer shall notify the SSS Medical Evaluation Department or the nearest SSS branch or representative office. However, in cases where the sickness or injury is sustained by the employee while working or within the premises of the employer, the employee shall be deemed to have notified his employer. The foregoing prescription period of NOTIFICATION does not apply to HOSPITAL confinement.
2. This form, after having been properly accomplished, shall be submitted in two (2) copies to the Employer by the sick employee or his representative. The employer shall submit the ORIGINAL to the SSS Medical Evaluation Department/Division within the prescribed period in instruction No. 1.
3. Use this form for the purpose of an INITIAL SICKNESS NOTIFICATION and INTERMEDIATE or FINAL SICKNESS NOTIFICATION, with the Attending Physician checking the proper box in PART II (Medical Certificate Portion) of this form.
4. For the items "CLINICAL SUMMARY" and "PROLONGED CONFINEMENT DUE TO" in Part II of this form, symptoms, physical findings, laboratory examinations and reports; X-ray plates; special diagnostic procedures, if any, must be submitted with this form. In cases of prolonged confinement, a progress report of the patient, in addition to those already stated, must be submitted. If spaces provided are not enough, attach an additional sheet herewith.
5. In cases of prolonged confinement or sickness of the employee that will extend beyond the initial estimate, on a previous estimated period, this form will be accomplished again by the employee and his Attending Physician, and submitted to the SSS within five (5) days requirement, after the previous estimate, and the Attending Physician will check the applicable boxes in PART II thereof.
6. For further details, refer to EC Circular No. 2-1 re: Sickness Notification requirement and procedures.
7. Physical examination will be held only in the morning from 8:00 to 12:00, Monday thru Friday. Those who cannot come should notify the SSS Medical Evaluation Department/Division immediately.