



Form B-300 (8/75)

Republic of the Philippines
SOCIAL SECURITY SYSTEM
EMPLOYEES NOTIFICATION

IMPORTANT: PLEASE READ INSTRUCTIONS AT THE BACK BEFORE FILLING UP FORM

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

Form with fields: 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 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.

Form with fields: NAME AND SIGNATURE OF MEMBER'S AUTHORIZED REPRESENTATIVE (If sick member cannot write, print right thumbmark), SIGNATURE OF CONFINED MEMBER, (RIGHT THUMBMARK)

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:

Form with fields: EXACT DATE EXAMINED ATTENDED, AGE, SEX, CIVIL STATUS, OCCUPATION, ADDRESS OF CONFINEMENT

THIS IS BEING SUBMITTED AS: (Check applicable box and state corresponding report/ findings)

- an INITIAL CERTIFICATE CLINICAL SUMMARY (Please read instruction #4 at the back)
an INTERMEDIATE
a FINAL CERTIFICATE
PROLONGED CONFINEMENT DUE TO:

DIAGNOSIS

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

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

- Confinement VERIFIED by employer/company physician
Confinement NOT VERIFIED by employer/company physician

NO. OF DAYS CONFINEMENT EXTENSION EFFECTIVE (Exact Date)

CONFINED AT

WILL BE FIT TO RESUME WORK ON (Exact Date)

Form with fields: PRINTED NAME & SIGNATURE OF ATTENDING PHYSICIAN, ADDRESS OF PHYSICIAN, REGISTRATION/ LICENSE NO.

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

Form with fields: 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.

EMPLOYER'S/ COMPANY'S ACKNOWLEDGEMENT RECEIPT (FROM SSS)

EMPLOYER'S ACKNOWLEDGEMENT RECEIPT (FROM COMPANY)

Form with fields: NAME OF CONFINED MEMBER, EMPLOYER, ADDRESS, CONFINEMENT PERIOD (Exact Date), START OF CONFINEMENT (Exact Date), 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 OF SIGNATURE OF COMPANY EXECUTIVE
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**FOR SSS USE ONLY
MEDICAL EVALUATION**

FINAL DIAGNOSIS

- APPROVED: _____ days, from _____ to _____
- REDUCED: _____ days, from _____ to _____
- DENIED: _____ days, from _____ to _____
- CLAIMANT TO COME FOR PHYSICAL EXAMINATION/CHEST X-ray

Submit: _____ Returned: _____

PREVIOUSLY APPROVED CONFINEMENT PERIOD: From _____ to _____
(Exact Date) (No. of Days)

SIGNATURE OF SSS MEDICAL EXAMINER/ RETAINER PHYSICIAN	DATE EVALUATED				
RECONSIDERATION/ EXTENSION:	No. of Days	FROM	TO	MEDICAL EXAMINER	DATE

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 Medical Evaluation Section of the nearest SSS branch or Representative Office. However, in cases where the sickness or injury 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 Medical Evaluation Section of the SSS branch or Representative Office within the prescribed period in instruction No. 1.
3. Use this form for the purposes of an INITIAL SICKNESS NOTIFICATION and INTERMEDIATE or FINAL SICKNESS NOTIFICATION, with the Attending Physician checking the proper box in the PART II, (Medical Certificate Portion) of this form.
4. For the items "CLINICAL SUMMARY" and " PROLONGED CONFINEMENT DUE TO" in PART II of the 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 Section of the SSS branch or Representative Office immediately.