Republic of the Philippines

SOCIAL SECURITY SYSTEM

EMPLOYEES NOTIFICATION

Form B-300 (8/75)

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

PART I CONFINED MEMBER'S NOTIFICATION (To be filled 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 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 acquire by him from physical/ mental examination of any person and all results of X-ray, laboratory and/or special diagnostic examinations. 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) (Please sign over your printed name)	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:

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)

DIAGNOSIS

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

PRINTED NAME & SIGNATURE OF ATTENDING PHYSICIAN

ADDRESS OF PHYSICIAN

REGISTRATION/ LICENSE NO.

☐ an INTERMEDIATE ☐ a FINAL CERTIFICATE

PROLONGED CONFINEMENT DUE TO:

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

NO. OF DAYS CONFINEMENT EXTENSION EFFECTIVE (Exact Date)

CONFINED AT

WILL BE FIT TO RESUME WORK ON (Exact Date)

PRINTED NAME & SIGNATURE OF EMPLOYER/ ATTENDING PHYSICIAN

ADDRESS OF PHYSICIAN

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

a) Much less 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? _____

DESCRIBE FULLY HOW ACCIDENT HAPPENED AND STATE WHAT EMPLOYEE WAS DOING WHEN INJURED.

Time, date & place of accident:

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

NAME OF CONFINED MEMBER

EMPLOYER

ADDRESS

CONFINEMENT PERIOD (Exact Date)

FROM	TO

RECEIVED BY	DATE RECEIVED

EMPLOYER'S ACKNOWLEDGEMENT RECEIPT (FROM COMPANY)

NAME OF CONFINED MEMBER

ADDRESS

EMPLOYER

START OF CONFINEMENT (Exact Date)

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)

COMPANY HAS NO WAY OF VERIFYING THE SICKNESS BECAUSE: (Check applicable box)

☐ He/she notified us only upon returning to work on

_____

The place of confinement was in

☐ Company has no physician

which is _____ kms away.

NATURE OF BUSINESS	NO. OF EMPLOYEES EMPLOYED	COMPANY ID NUMBER	PRINTED NAME OF SIGNATURE OF COMPANY EXECUTIVE

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.