**CLAIM NO.**

RE-FILING CLAIM NO.

THIS FORM MAY BE REPRODUCED AND IS NOT FOR SALE. THIS CAN ALSO BE DOWNLOADED THRU THE SSS WEBSITE AT www.sss.gov.ph

PLEASE READ THE INSTRUCTIONS AND REMINDER AT THE BACK BEFORE FILLING OUT THIS FORM. PRINT ALL INFORMATION IN CAPITAL LETTERS AND **USE BLACK INK ONLY.**

A. PERSONAL DATA

B. CERTIFICATION

I certify that the information provided in this form are true and correct.

PRINTED NAME

SIGNATURE

DATE

If member cannot sign, affix fingerprints. Please read Instruction No. 6 of the form.

Below are the witnesses to fingerprinting:

1) _____
 PRINTED NAME SIGNATURE DATE

 ADDRESS & CONTACT NUMBER

2) _____
 PRINTED NAME SIGNATURE DATE

 ADDRESS & CONTACT NUMBER

RIGHT THUMB	RIGHT INDEX
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A. EMPLOYER DATA

EMPLOYER ID NUMBER 0 3 9 0 6 6 7 3 3 1 0 0 0										NAME OF EMPLOYER/REGISTERED BUSINESS NAME ALL NATION SECURITY & INVESTIGATION SERVICES, INC.										E-MAIL ADDRESS allnation_1996@yahoo.com																							
BUSINESS ADDRESS (NO. & STREET) 5TH FLOOR DRB BLDG.										(BARANGAY) AGUINALDO HIGHWAY										(TOWN/ DISTRICT) PALICO IV										(CITY/PROVINCE) IMUS CAVITE										ZIP CODE 4 1 0 3			
START OF SICK LEAVE (MMDDYYYY)										NOTIFICATION FORM WAS RECEIVED BY US ON (MMDDYYYY)										E-NOTIFICATION DATE (MMDDYYYY)										ACCIDENT/SICKNESS OCCURRED WHILE ☐ Working ☐ In Co. Premises ☐ On Vacation ☐ On Strike ☐ Co. Shutdown ☐ Under Suspension													

B. CERTIFICATION

I certify that the above information are true and correct and that the reported accident/illness is duly recorded in the Employer's Logbook for EC Claim under page number _____ and entry number _____.

_____ SIGNATURE OVER PRINTED NAME EMPLOYER/AUTHORIZED REPRESENTATIVE	_____ OFFICIAL DESIGNATION	_____ DATE
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PART III - MEDICAL CERTIFICATE (TO BE FILLED OUT BY THE ATTENDING PHYSICIAN)

BRIEF MEDICAL HISTORY AND PERTINENT FINDINGS

ATTENDING PHYSICIAN'S CERTIFICATION

I certify that I have seen and examined above-named patient on _____ and in my opinion, confinement including recuperation period may last _____ days.

(DATE) (no. of days)

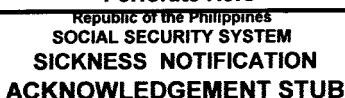
DIAGNOSIS: _____ FIT TO WORK: _____

PLACE OF CONFINEMENT		START OF CONFINEMENT (MMDDYYYY)		NAME OF HOSPITAL (if confined in a hospital)	
☐ HOME	☐ HOSPITAL				
PRINTED NAME AND SIGNATURE					LICENSE NO.
ADDRESS OF PHYSICIAN'S CLINIC/HOSPITAL		(NO. & STREET)	(BARANGAY)	(TOWN/ DISTRICT)	(CITY/PROVINCE)
					ZIP CODE

PART IV - TO BE FILLED OUT BY SSS PERSONNEL

RECEIVED BY (FOR MEMBER SERVICES SECTION)			RECEIVED BY (FOR MEDICAL EVALUATION SECTION)		
SIGNATURE OVER PRINTED NAME	DATE	TIME	SIGNATURE OVER PRINTED NAME	DATE	TIME

Perforate Here



SS NUMBER/CRN (IF ANY)										NAME OF MEMBER										(LAST NAME)										(FIRSTNAME)										(MIDDLE NAME)										(SUFFIX)																													
RECEIVED BY																																																																															
SIGNATURE OVER PRINTED NAME																				POSITION TITLE																				DATE & TIME																				SSS BRANCH																			

