Republic of the Philippines
SOCIAL SECURITY SYSTEM

SICKNESS NOTIFICATION
SSS Form CLD-9N (Rev. 10/74)

IMPORTANT
BEFORE ACCOMPLISHING
PLEASE READ INSTRUCTIONS

S N NO.:

PART I CONFINED MEMBER'S NOTIFICATION

Date : _____

(This Block to be accomplished by confined member. Please print all data.)

Name of Confined Member:	SS Number:	Tax Account Number:
Name of Employer:	Residence:	
Address of Employer:	Exact Date Confinement Started	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 my person and all results of X-ray, laboratory, and/or special diagnostic examination. I further waive all information held privilege by law.

Name & Signature of member's Authorized Representative (IF SICK MEMBER CANNOT WRITE: PRINT RIGHT THUMBMARK) (Please sign over your printed name)	(RIGHT THUMBMARK)	(Signature of Confined Member)

PART II MEDICAL CERTIFICATE

Date: _____

(This Block to be filled by the Attending Physician)

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

1. (a) Exact Date Examined/Attended:	(b) Age:	(c) Sex:	(d) Civil Status:	(e) Occupation:

2. Address of Confinement :

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

☐ an INITIAL certificate ☐ an INTERMEDIATE certificate ☐ a FINAL certificate

CLINICAL SUMMARY: (Please read accompanying instructions.)

3(a) PROLONGED CONFINEMENT DUE TO:

(Give progress report of patient)

4. DIAGNOSIS:

4(a) FINAL DIAGNOSIS

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

NO. OF DAYS OF CONFINEMENT EXTENSION (days)

EFFECTIVE (Exact Date)

☐ Confinement NOT VERIFIED by employer/company physician

CONFINED AT

☐ Confinement VERIFIED by employer/company physician

WILL BE FIT TO RESUME WORK ON (Exact Date)

PRINTED NAME & SIGNATURE OF ATTENDING PHYSICIAN		PRINTED NAME & SIGNATURE OF EMPLOYER/COMPANY PHYSICIAN	
ADDRESS		ADDRESS	
REGISTRATION NO.	TELEPHONE NO.	REGISTRATION NO.	TELEPHONE NO.

(PART III of this form at back also to be filled up)

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) FROM TO	START OF CONFINEMENT (Exact Date)
RECEIVED BY	NOTIFICATION RECEIVED BY
DATE RECEIVED	DATE RECEIVED

PART III (THIS BLOCK TO BE FILLED BY EMPLOYER)

1. His/her confinement started: (Exact Date)

2. Sickness Notification was received by us on _____ 19____ thru:
☐ Phone, rec'd by _____ (Date) _____ ☐ Handcarried by _____ (Date) _____ ☐ Mail _____ (Postmark Date)

3. Sickness occurred while:
☐ working ☐ in company premises ☐ on leave ☐ under suspension ☐ on strike ☐ company's "shut down"
other reason (s) _____

4. COMPANY HAS NO WAY OF VERIFYING THE SICKNESS BECAUSE:
☐ He/she notified us only upon returning to work on _____
☐ Company has no physician ☐ The place of confinement was in _____ which is _____ kms. away

Company ID Number _____

Sign Here _____
PRINTED NAME & Signature of Company Executive

MEDICAL EVALUATION

(Do not fill this block. For SSS use only)

FINAL DIAGNOSIS:
☐ APPROVED: _____ days, from _____ to _____
☐ REDUCED: _____ days, from _____ to _____
☐ DENIED: _____
☐ Claimant to come for physical examination/chest X-ray in the morning only. Bring SSS Form E-1 or SSS ID. _____
☐ Submit: _____
☐ Returned: _____

RECONSIDERATION/EXTENSION
No. of Days _____
From: _____
To: _____

(Date) | MEDICAL EXAMINER

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

_____ (Date)

_____ SSS Medical Examiner/Retainer Physician

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. The employer in turn shall notify the SSS Medical Department or the Medical Division of the nearest SSS branch of his employee's confinement within five (5) calendar days after the receipt of the notification from his employee. 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. In such cases, the 5-day period for the employer to notify the SSS shall start on the day immediately following the 1st day of sickness or injury. 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 Department or the Medical Division of the nearest SSS branch, within the prescribed period in instruction No. (1).

3. This form is to be used 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 also 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 hereof.

6. For further details, refer to Circular No. 91-T, dated October 31, 1972, re: Sickness Notification requirements 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 Department or the Medical Division of the nearest SSS branch immediately.