Republic of the Philippines
SOCIAL SECURITY SYSTEM

MEDICAL CERTIFICATE

(SSS FORM MMD - 102)

1. EMPLOYEE'S GENERAL DATA NAME (Last, First, M.I.)	AGE	SEX	CIVIL STATUS	OCCUPATION

DATE EXAMINED/ATTENDED

From To

2. BRIEF CLINICAL HISTORY AND PRESENT PHYSICAL FINDINGS (Attach extra sheet if needed)

3. X-RAY LABORATORY AND/OR SPECIAL DIAGNOSTIC EXAMINATION (Attach extra sheet if needed)

4. FINAL DIAGNOSIS

5. EXACT DATE OF DISABILITY

6. KIND OF SURGICAL OPERATION PERFORMED, IF ANY
(If claim is for disability attach operating room record)

7. DATE OF OPERATION

8. PERIOD OF MEDICAL ATTENDANCE/ TREATMENT/ACTUAL SICKNESS	CONVALESCING OR RECUPERATION PERIOD
From To	From To

PLACE OR PLACES WHERE THE PATIENT WAS CONFINED DURING MY MEDICAL ATTENDANCE AND/OR TREATMENT

PLACE/S OF CONFINEMENT	DATE	
	FROM	TO

9. OTHER REMARKS

PURSUANT TO SECTION 28 OF THE SOCIAL SECURITY LAW, AS AMENDED, ANYONE WHO RESORTS TO MISREPRESENTATION OR CONCEALMENT OF A MATERIAL FACT OR WHO IS A PARTY THERETO, FOR THE PURPOSE OF CAUSING ANY PAYMENT OF FRAUDULENT CLAIM OR BENEFIT UNDER THE SAID LAW, SHALL SUFFER THE PENALTIES OF FINE OR IMPRISONMENT OR BOTH.

I HEREBY WARRANT THAT I HAVE THOROUGHLY EXAMINED THE HEREIN PATIENT/CLAIMANT AND THAT THE FOREGOING INFORMATION ARE TRUE AND CORRECT.

PHYSICIAN'S SIGNATURE OVER PRINTED NAME	LICENSE/CERTIFICATE NO.	DATE OF ACCOMPLISHMENT

ADDRESS

STATEMENT OF WAIVER

I HEREBY WAIVE ANY RIGHT OR PRIVILEGE I MAY HAVE ON ALL INFORMATION PERTAINING TO MY MEDICAL HISTORY AND I CONSENT TO ALLOW SSS TO EXAMINE ALL MY MEDICAL RECORDS.

RIGHT OR LEFT THUMBPRINT OF PATIENT/CLAIMANT IF ILLITERATE OR UNABLE TO WRITE

PATIENT'S/CLAIMANT'S SIGNATURE

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