And has been absent from……/……/……..on account of incapacity which <u>was</u> /<u>was not due</u>
Day Month Year

to an injury sustained during the course of his/her employment here. He/She returned to work on

……./……./……../ Please indicate vacation or days off if applicable from:
Day Month Year

……../……/…….. to ……./……/……
Day Month Year Day Month Year

LIST BELOW THE EMPLOYEE'S EARNINGS FOR THE PREVIOUS MONTH. IF HE/SHE IS PAID MONTHLY, INDICATE THE NUMBER OF WEEKS WORKED USING SATURDAY'S DATE AS YOUR GUIDELINE.

Weekly paid employee	Monthly paid employee
1)……20……..$.....	$.....
2)……20……..$.....	For the month of ……20……..
3)……20……....$.....	Number of weeks worked……
4)……20……$.....	
5)…….20……$.....	

Name of employer……..

Registration number of employer……..

Name of person giving information……..

SIGNATURE……...**DATE**……

26 weeks? **8 to 13?**

☐ YES ☐ NO ☐ YES ☐ NO

Insurable earnings for……..20……. $..... .No of weeks……..
Insurable earnings for…… ..20……. $.....No of weeks……..
Insurable earnings for……..20……. $..... .....No of weeks……..

_____

TOTAL _____

Prepared by…… …….. .**Date**……

ANTIGUA-BARBUDA SOCIAL SECURITY ACT
APPLICATION FOR SICKNESS BENEFIT

TO PERSONS CLAIMING BENEFIT

You are required to take this form to your employer after a State Registered Medical Practitioner has filled out sections A & B, and you have filled out section C. Your employer will then fill out section D. You must then bring or send it to the Social Security Office.

To avoid unnecessary delay in the payment of your benefit, please ensure all aspects of section C are properly filled out.

THIS FORM SHOULD REACH THE SOCIAL SECURITY OFFICE NOT LATER THAN 21 DAYS AFTER COMMENCEMENT OF THE ILLNESS

To Employer

You are kindly asked to fill out section D of this form, and to certify that information given by you is correct. Understanding that you can be prosecuted if you knowingly give incorrect information.

Kindly detach and retain Section B of this form for your records. If you receive the form after the employee has resumed work, kindly indicate when he/she resumed.

SECTION A

(to be completed by a State Registered Medical Practitioner)

Mr/Mrs/Miss……..

I hereby certify that on……/……../……, I examined you and found you suffering
Day Month Year

from Code……. my opinion, you will be fit to resume work on ……/……/…….
Day Month Year

Occupational Injury

☐ **Yes** ☐ **No**

Name……..

(Please Print)

Address…….

SECTION B

(Medical Certificate for employer)

I hereby certify that on……/……/…….. I examined…….
Day Month Year

……..and by reason of illness, he/she is incapacitated. In my opinion, he/she will be fit to resume

work on……/……/……..
Day Month Year

SECTION C

(To completed by Claimant)

Name……Social Security No……...

Mailing Address……..…Physical Address…….

Telephone Nos (home)……Cell……..

PAYMENT OPTION

☐ **Mail**

☐ **Do Not Mail**

Name of Bank……...

Account Number……..

I am employed by……

The address of my employer is……

During the three months immediately before my sickness, my other employer(s) was/were:

	Employer	**Address**
a)	**……**	**……**
b)	**……**	**……**
c)	**……**	**……**

…… **……**

Signature **Date**

SECTION D

(TO BE COMPLETED BY EMPLOYER)

This is to certify that Mr/Mrs/Miss ..……..……...

Has been employed in this establishment from.. . …….20…….. His/Her present weekly/monthly

earnings being $..... He/she last worked on ……20….....