

CERTIFICATION

This certifies the following relative to the Application for Employees Compensation (EC), under Presidential Decree (PD) No. 626, COVID-19 claim of:

Name of Employee : _____

Employee Position : _____

Office : WESTERN VISAYAS MEDICAL CENTER

Last Day of Work before COVID Infection:
Inclusive Date of Leave of Absence or Quarantine Leave:
Statement of Actual Duties <i>Additional sheet/s may be used, if necessary.</i>
Circumstances Leading to Infection: <i>Additional sheet/s may be used, if necessary.</i> 1. Exposure for the orientation of the newly awarded security agency.
Description of Increased Risk in the Performance of Duties, if applicable <i>Additional sheet/s may be used, if necessary.</i>
Date of Return to Work:

Issued on this _____ of _____, 2022, for whatever legal purpose it may serve.

Signature over Printed Name of
Immediate Supervisor

Signature over Printed Name of
Human Resource Officer