THE PROVINCIAL EMPLOYEES' SOCIAL SECURITY INSTITUTION SERVANTS' (MEDICAL ATTENDANCE) REGULATIONS, 1967

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1. Title and date of commencement: (1) These regulations may be called the Provincial Employees' Social Security Institution (Medical Attendance) Regulations, 1967.

(2) They shall apply to all the employees of the Institution and their families.

(3) They shall come into force at once.

2. Definitions: In these regulations unless the context otherwise requires:-

(i) The following expressions shall have the meanings thereby respectively assigned to them:-

(a) "Authorized Medical Attendant" means the Medical Official-in-charge of Social Security Dispensary or any other doctor appointed by the Institution to provide medical treatment to its employees.

(b) "Family" means the wife / husband, and dependent children of the employees.

(c) "Ordinance" means the Provincial Employees' Social Security Ordinance, 1965.

(d) "Hospital" means a Social Security Dispensary / Hospital or any other hospital / dispensary with which arrangements have been made by the Institution for the treatment of its employees.

(e) "Medical Attendance" means attendance in the hospital or at the residence of the employees including use of such pathological, bacteriological, radiological and other methods of investigation

for the purpose of diagnosis and reference to specialist for examination treatment as are considered necessary by the authorized Medical Attendant.

(f) "Patient" means an employee or a member of family to whom these regulations apply and who falls ill.

(g) "Treatment" means the use of medical, surgical, maternity and other facilities available at the hospital and includes ------

(1) The employment of such pathological, bacteriological, radiological or other methods as is considered necessary by the authorized Medical Attendant.

(2) The supply of medicines, vaccines, sera or other therapeutic substances not ordinarily so available as the authorized Medical Attendant may certify in writing to be essential for the recovery or for the prevention of deterioration in the condition of the patient.

(3) Such accommodation as is ordinarily provided in the hospital and is suited to his status.

(4) Such nursing as is ordinarily provided to patient in the hospital.

(5) Consultation with the specialist.

(ii) other expressions shall have the meanings hereby respectively assigned to them.

3. Employees of the Institution shall be entitled to free medical attendance by the Authorized Medical Attendant.

4. When an employee of the Institution is entitled under Regulation 3 to receive medical attendance, any amount paid by him on account of such medical attendance shall on the production of the certificate in writing from the Authorized Medical Attendant in this behalf be reimbursed to him by the Institution.

5. If the Authorized Medical Attendant is of the opinion that the condition of the patient is of such a serious or special nature as to require medical attendance by a person other than himself, he may-----

(a) Send the patient to the appropriate specialist.

(b) If the patient is too ill to travel, summon such a Specialist to attend upon him at his residence; and

(c) Recommend treatment abroad.

6. If an employee is treated in a hospital, where he has to pay for his treatment, he shall himself make the payment in the first instance and recover the amount from the Institution afterwards. For this, he should obtain from the hospital authorities a copy if possible of the printed tariff of the hospital, a bill in full detail, and also a duly signed receipt in token of having made the payment and present them to his office. The office will check the bill with tariff and after obtaining the advice of the Medical Adviser, if necessary, draw the amount on a contingent bill form, for which the hospital bill and receipt will form the vouchers. The amount shall then he disbursed to the employee.

7. If the Authorized Medical Attendant is of the opinion that owing to the absence or remoteness of a suitable hospital or to the illness an employee cannot be given treatment at the hospital such an employee shall receive treatment at his residence.

8. If any question arises as to whether any service is included in the medical attendance or treatment, it shall be referred to the Medical Adviser and his decision shall be final.

-----: o: -----

APPENDIX I

ادارہ معاشرتی تحفظ صوبائی ملازمین

(چندوں اور آجرتوں کا تصدیق نامہ)

مطالبہ انفاع بیماری طبی ونگہداشت

تحفظ یافتہ شخص کا نام --------- معاشرتی تحفظ

میں تصدیق کرتا ہوں کہ مذکورہ بالا شخص گزشتہ ۱۲/٦ ماہ میں (i) کم از کم ۱۸۰/۹۰ یوم تک میرے پاس ملازم رہا ہے ۔ (اگر نہ ہو تو) (ii) گزشتہ ۱۲/٦ ماہ سے ہر ایک ماہ میں اس عورت / مرد کے ایام کار کی تعداد حسب ذیل ہے۔

نمبر شمار	ماہ	تعداد ایام	نمبر شمار	ماہ	تعداد ایام	نمبر شمار	ماہ	تعداد ایام	نمبر شمار	ماہ	تعداد ایام
۱			۵			۳			۷		
۲			٦			۴			۸		

(iii) اس کے کام کی آخری تاریخ --------- تھی۔

(iv) آجر کا رجسٹرڈ نمبر

آجر کی مہر

تاریخ

دستخط برائے آجر

فرم میں عہدہ

APPENDIX II

ادارہ معاشرتی تحفظ صوبائی ملازمین

آجر کی جانب سے ادارہ معاشرتی تحفظ کو سنگین حادثے کی اطلاع

(ہر سنگین حادثہ کے وقو ع سے چوبیس گھنٹے کے اندر اندر ادارہ کے
نزدیک ترین مقامی دفتر کو روانہ کی جائے)

فرم کا نام _____

پتہ _____ آجر کا رجسٹریشن نمبر | | | |

ٹیلیفون نمبر _____

حصہ ۱۔ تصدیق کی جاتی ہے کہ بتاریخ _____ ۲۰ بوقت _____صبح / شام

مسمی _____ پتہ _____

رجسٹریشن نمبر | | | | | | | | کو بہ دوران ملازمت حسب ذیل سنگین حادثہ پیش آیا ہے۔

(ضرر کی نوعیت اور شدت کا مختصر بیان درج کریں)

_____

حصہ ۲ ۔ حادثے کے واقعات یہ ہیں(حادثے کے واقع ہونے کا مختصر بیان درج کریں)

_____

حصہ ۳۔ آجر کے مشاہدات ۔

میں تصدیق کرتا ہوں کہ مندرجہ بالا بیان میرے علم اور یقین کی حد تک درست ہے اور میں اسکی صحت کا کلی طور پر ذمہ دار ہوں۔

(دستخط) _____

عہدہ _____

تاریخ _____ ۲۰

فرم کی مہر _____

APPENDIX III

Provincial Employees' Social Security Institution

EMPLOYER'S REGISTRATION FORM

Registration Number Allotted

(for official use only)

WRITE LEGIBLY PLEASE

Name of firm _____

Employer's name _____

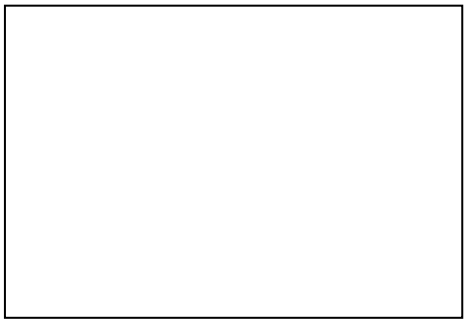
(if different)

Address of principal place of business _____

Telephone Number(s) _____

Nature of business _____

Number of employees liable to become secured persons _____



STAMP OF FIRM

(Approximate)

Signature of employer _____

Date _____20

Form R-1

P.T.O.

FOR OFFICIAL USE ONLY

ACTION	ACTION TAKEN	
	Initial	Date
Registration form checked Name of employer entered in register Registration number allotted as shown overleaf Form R-3 and R-4 prepared and issued		

APPENDIX IV

Provincial Employees' Social Security Institution

PARTICULARS OF SECURED PERSON

Name _____

_____

Address _____

_____

Sex	*Man	
	*Woman	

Date of birth (if known)

Day Month Year OR Age Years

Place of birth _____ Occupation _____

Father's name _____

Marital Status of	Single		Married		Widower		Widow	

secured person	*		*		*		*	

* Mark with X in appropriate space.

If married, state name of wife or wives _____

_____

_____

If a married woman, state name of husband _____

Signature of secured person _____ OR

STAMP OF EMPLOYER RIGHT THUMB PRINT

FOR OFFICIAL USE ONLY

Special Security Number allotted

Form R-2

APPENDIX V

Provincial Employees' Social Security Institution

Return of Employees liable to become secured persons

Name of Employer _____

Registration Number | | | |

Address _____

I hereby declare that every person employed as an employee within the meaning of Section 2 (8) of the West Pakistan Employees' Social Security Ordinance, 1965, on _____ in this factory / establishment in receipt of remuneration not exceeding Rs. 20 per day, has been included in this list (Excepting only those employees in respect of whom registration forms (Form R-2) have already been submitted).

Signature _____

Date _____ 20 Titles _____

S.No.	Name of Employee	Father's Name	Work Number (if any)	Registration Number allotted by Institution (for official use only)
1.	2	3.	4.	5.

Enclosures continuation sheets (Forms R 3-A) numbered to Form R-3

APPENDIX VI

Record of Employment **Record of Employment**

Employer's Registration Number	Period of Employment		Employer's Signature and Stamp	Employer's Registration Number	Period of Employment		Employer's Signature and Stamp
	From	To			From	To	

Secured Person's Registration Card

Entries on page 2 or 3 of this card should be made whenever a secured person starts to work for an employer or leaves his employment.

This Registration Card should be produced by the secured person (or his agent) whenever a benefit is claimed.

Warning: Any person who knowingly makes or causes to be made any false statement or false representation; or produces or furnishes, or causes or knowingly allows to be produced or furnished

Provincial Employee's Social Security Institution

Secured Person's Registration Card

This is certifying that _____ ___ has been registered as a secured person within the meaning of the Provincial Employees' Social Security Ordinance, No. X of 1965 on _____ 20, under the number inscribed above, in respect of this employment by.

Photo

This card must be deposited at a Local

any document or information which he knows to be false in a material particular, is liable to be punished with imprisonment not exceeding 3 months or by a fine of Rs. 1,000 or both.

The address of your Dispensary:

_____

_____

Office of the Institution when a secured person ceases to work in an establishment to which the above-mentioned Ordinance has been applied.

Signature, Thumb impression.

Visible Identification

Marks _____

(Keep this card carefully. If lost, a duplicate may be obtained, from the nearest Local Office of the Institution for which a charge of fifty paisa may be made).

Form R-5

APPENDIX VII

Provincial Employees' Social Security Institution

Month of _____20 Registered No.

Name of Employer _____

Serial No.	Social Security Number	Name of employee (insert in	Gross Wages per			Time Worked		Amount on which Contributions are payable		Employees' Social Security Contribution		Employers' Social Security Contribution		Remarks
			Day	Week	Month	Number of *		Rs.	Ps.	Rs.	Ps.	Rs.	Ps.	
						Days	weeks							

Form C-I *Use appropriate columns.

*I CERTIFY that this Schedule includes the names of all insurable employees of this firm, and that all information given regarding their employment and wages is correct.

Signature _____

Position in firm _____

Date _____

Total					
	Add Employee's Contribution				
	Amount payable				

* To be completed when only one Schedule is submitted, otherwise, complete certificate on Form C-2

APPENDIX VIII

ادارہ معاشرتی تحفظ صوبائی ملازمین

حادثے کی صورت میں تصدیق نامہ

میں تصدیق کرتا ہوں کہ مذکورہ بالا شخص _____

باریخ حادثہ یا ملازمتی بیمار(Occupational disease)کے وقت میری ملازمت میں تھا۔

روپے پیسے

۲۔ اس کی شرح اجر ت

تھی۔

۳۔ حادثہ کی اطلاع B-3 پر دی گئی ہے / نہیں دی گئی ہے۔

آجر کا رجسٹرڈ نمبر

تاریخ _____

دستخط برائے آجر _____

عہدہ _____

آجر کی مہر

فارم B 2-A

APPENDIX IX

Provincial Employees' Social Security Institution

MEDICAL CERTIFICATE OF | | | | | | | |

INCAPACITY FOR WORK

Mr. / Mst. / Miss _____

(Name in full)

This is to certify that I have examined the person named above and find that he / she is suffering from _____ _____ since _____ which incapacitates him / her from work. In my opinion, he / she will take about _____ days to resume work.

Date _____ Medical Practitioner

Form M-I. (Front)

مطالبہ برائے معاوضہ بیماری / چوٹ

میں مسمی / مسمات _____ ساکن _____ بیان کرتی ہوں۔

(نام جگہ) (تاریخ)

(۱) میں نے _____کو آخری دن _____ میں کام کیا اور _____

___ صبح / شام ہر کام چھوڑا۔

(وقت) (نام جگہ)

(۲) میری معذوری حادثہ کی وجہ سے ہوئی جو کہ _____

(وقت)

میں _____ صبح / شام مجھے پیش آیا۔

(۳) میں نے تاریخ معذوری کے دن سے کوئی کام نہیں کیا ہے۔ لہذا مجھے معاوضہ برائے بیماری / چوٹ دیا جائے۔

تاریخ _____ ۲۰ دستخط _____

یا

نشان انگوٹھا

Form M-1 Back

APPENDIX X

Provincial Employees Social Security Institution

MEDICAL CERTIFICATE OF INCAPACITY FOR WORK

Serial No. _____

INTERMEDIATE

(Name in full)

Mr., Mrs./Miss _____

Certified that I have examined the person named above and find that he/she is still incapable of work which he/she is expected to resume after about _____ days/weeks. He / she are required to attend the dispensary on _____ for re-assessment of his/her condition.

Medical Practitioner

Form M-2 (Front)

مطالبہ برائے معاوضہ بیماری / چوٹ

میں مسمی / مسمات _____ ساکن _____ بیان کرتا/کرتی ہوں کہ بوجہ معذوری میں نے سابقہ ڈاکٹری سرٹیفیکٹ کی تاریخ کے بعد سے کوئی کام نہیں کیا ہے۔ لہذا معاوضہ کا مطالبہ کرتا/ کرتی ہوں۔

تاریخ _____ ۲۰ دستخط _____

یا

نشان انگوٹھا

Form M-2 (Back)

APPENDIX XI

Provincial Employees' Social Security Institution

CERTIFICATE OF FITNESS TO RESUME WORK

Serial No. _____

Mr. / Mrs. / Miss _____

Date _____ _____

Medical Practitioner

Form M-3 (Front)

مطالبہ برائے معاوضہ بیماری / چوٹ

میں مسمی / مسمات _____ ساکن _____ بیان کرتا/کرتی ہوں کہ بوجہ معذوری میں نے سابقہ ڈاکٹری سرٹیفیکٹ کی تاریخ کے بعد سے کوئی کام نہیں کیا ہے۔ لہذا معاوضہ کا مطالبہ کرتا/ کرتی ہوں۔

تاریخ _____ ۲۰ دستخط _____

یا

نشان انگوٹھا

Form M-3-2 (Back)