Processing Officer:	Approving Officer:	Encoder:

DEPARTMENT OF HEALTH

Philippine Registry for Persons with Disabilities Version 4.0

Application Form

1. ☐ NEW APPLICANT ☐ RENEWAL

PLEASE FILL OUT ALL FIELDS MARKED BY * (ASTERISK)

2. PERSONS WITH DISABILITY NUMBER (RR-PPMM-BBB-NNNNNNN):	3. DATE APPLIED (mm/dd/yyy):

4. PERSONAL INFORMATION

* LAST NAME:	* FIRST NAME:	* MIDDLE NAME:	SUFFIX:

*5. DATE OF BIRTH (mm-dd-yyyy)	*AGE:	*6. SEX: ☐ MALE ☐ FEMALE	* BLOOD TYPE: ☐ A+ ☐ O+ ☐ A- ☐ O- ☐ B+ ☐ AB+ ☐ B- ☐ AB-

*7. CIVIL STATUS: ☐ Single ☐ Separated ☐ Cohabitation (Live-In) ☐ Married ☐ Widower

*8. TYPE OF DISABILITY:

- ☐ Deaf or Hard of Hearing
- ☐ Intellectual Disability
- ☐ Learning Disability
- ☐ Mental Disability
- ☐ Physical Disability
- ☐ Psychosocial Disability
- ☐ Speech and Language Impairment
- ☐ Visual Disability
- ☐ Cancer (RA 11215)
- ☐ Rare Disease (RA 10747)

*9. CAUSE OF DISABILITY

- ☐ Congenital / Inborn
- ☐ ADHD
- ☐ Cerebral Palsy
- ☐ Down Syndrome
- ☐ Other, Specify: _____
- ☐ Acquired
- ☐ Chronic Illness
- ☐ Cerebral Palsy
- ☐ Injury
- ☐ Other, Specify: _____

10. RESIDENCE ADDRESS

*HOUSE NO. AND STREET:

*BARANGAY:	MUNICIPALITY: CALOOCAN CITY	PROVINCE: METRO MANILA, 3RD DISTRICT	REGION: NATIONAL CAPITAL REGION
11. CONTACT DETAILS	LANDLINE NO.:	*MOBILE NO.:	EMAIL ADDRESS:

*12. EDUCATIONAL ATTAINMENT:

- ☐ None
- ☐ Kindergarten
- ☐ Elementary
- ☐ Junior High School
- ☐ Senior High School
- ☐ College
- ☐ Vocational
- ☐ Post Graduate

*13. STATUS OF EMPLOYMENT:

- ☐ Employed
- ☐ Unemployed
- ☐ Self-Employed

*13A. CATEGORY OF EMPLOYMENT:

- ☐ Government
- ☐ Private

*13B. TYPES OF EMPLOYMENT:

- ☐ Permanent / Regular
- ☐ Seasonal
- ☐ Casual
- ☐ Emergency

*14. OCCUPATION:

- ☐ Managers
- ☐ Professionals
- ☐ Technician and Associate
- ☐ Clerical Support Workers
- ☐ Service and Sales Workers
- ☐ Skilled Agricultural, Forestry and Fishery Workers
- ☐ Craft and Related Trade Workers
- ☐ Plant and Machine Operators and Assemblers
- ☐ Elementary Occupations
- ☐ Armed Forces Occupation
- ☐ Others, Specify: _____

15. ORGANIZATION INFORMATION:

Organization Affiliated:	Contact Person:	Office Address:	Tel No.:

16. ID REFERENCE NO.:

SSS NO.:	GSIS NO.:	PAG-IBIG NO.:	PSN NO.:	PHILHEALTH NO.:

17. FAMILY BACKGROUND	LAST NAME	FIRST NAME	MIDDLE NAME
FATHER'S NAME			
MOTHER'S NAME			

18. CONTACT PERSON

*IN CASE OF EMERGENCY:			
*CONTACT NUMBER:			

19. ACCOMPLISHED BY:	LAST NAME	FIRST NAME	MIDDLE NAME
o APPLICANT			
o GUARDIAN			
o REPRESENTATIVE			
20. NAME OF CERTIFYING PHYSICIAN: LICENSE NO.:			
22. NAME OF REPORTING UNIT (OFFICE/SECTION):			
23. CONTROL NO.:			

NEW	RENEWAL	IF REPRESENTATIVE	IF LOST
1. 2x2 Picture (2pc)	1. 2X2 Picture (2pc)	1. 2X2 Picture (2pc)	1. 2X2 Picture (2pc)
2. 1x1 Picture (1pc)	2. 1x1 Picture (1pc)	2. 1x1 Picture (1pc)	2. 1x1 Picture (1pc)
3. Barangay Certificate Proof of Residency: **FOR PWD PURPOSES** with Barangay Contact No. (Original Copy)	3. Barangay Certificate Proof of Residency: **FOR PWD PURPOSES** with Barangay Contact No. (Original Copy)	3. Barangay Certificate Proof of Residency: **FOR PWD PURPOSES** With Barangay Contact No. **INDICATE REPRESENTATIVE'S NAME** (Original Copy)	3. Barangay Certificate Proof of Residency: **FOR PWD PURPOSES** with Barangay Contact No. (Original Copy)
4. Two copies of Latest Certificate of Disability (1 Original Copy & 1 Xerox Copy)	4. Two copies of Latest Certificate of Disability (1 Original Copy & 1 Xerox Copy)	4. Two copies of Latest Certificate of Disability (1 Original Copy & 1 Xerox Copy)	4. Two copies of Latest Certificate of Disability (1 Original Copy & 1 Xerox Copy)
5. Completely Filled up Form	5. Completely Filled up Form	5. Completely Filled up Form	5. Completely Filled up Form
6. Xerox of Any Valid ID / Birth Certificate	6. Xerox of Any Valid ID / Birth Certificate	6. Xerox of Any Valid ID / Birth Certificate	6. Xerox of Any Valid ID / Birth Certificate
	7. Surrender OLD PWD ID and BOOKLET	7. Letter of Authorization	7. Affidavit of Loss
		8. ID of Representative	
		9. Picture of Applicant holding dated Newspaper or Calendar together with Representative	

HUMINGI po kayo ng **CERTIFICATE OF DISABILITY** mula sa inyong Doctor na kung saan nakasaad kung ano pong disability mayroon kayo ayon sa kanyang assessment na base sa **10 KLASE NG DISABILITY**. Pakilinaw lang po na kailangan na ang kanyang certification ay nakalagay sa kanyang prescription pad o sa letter head ng kanyang clinic at malinaw po na nakasulat ang kanyang pangalan at license no.

Ang **Medical Certificate of Disability** ay nakasaad ang:
1. Diagnose (ano ang sakit)
2. Ano ang functional limitation (resulta ng karamdaman)
3. Ano ang Type of Disability

TYPE OF DISABILITY

NOTE:

CERTIFICATE OF DISABILITY MUST BE ISSUED BY: SPECIALIST WITH CAPACITY TO DETERMINE DISABILITY.

Check the appropriate box/es for the Type/s of Disability sustained by the *Person with Disability*. One or more items can be checked for this field.

Deaf or Hard of Hearing - refers to people with hearing loss, implies little or no hearing/ranging from mild to severe. Hearing loss, also known as hearing impairment means the complete or partial loss of the ability to hear from one or both ears with 26 dB or greater hearing threshold, averaged at frequencies' 0.5, 1, 2, 4 kilohertz.

Intellectual Disability - a significantly reduced ability to understand new or complex information and to learn and apply new skills.

Learning Disability - persons who, although normal in sensory, emotional and intellectual abilities, exhibit disorders in perception, listening, thinking, reading, writing, spelling, and arithmetic.

Mental Disability - disability resulting from organic brain syndrome and or mental illness (psychotic or non-psychotic disorder)

Physical Disability - is a restriction of ability due to any physical impairment that affects a person's mobility, function, endurance or stamina to sustain prolonged physical ability, dexterity to perform tasks skillfully and quality of life. Causes may be hereditary or acquired from trauma, infection, surgical or medical condition and include the following disorders, namely: ***(1)*** Musculoskeletal or orthopedic disorders **(2)** Neurological disorders **(3)** Cardiopulmonary disorders **(4)** Pediatric and congenital disorders

Psychosocial Disability - any acquired behavioral, cognitive, emotional or social impairment that limits one or more activities necessary to effective interpersonal transactions and other civilizing process or activities to daily living such as but not limited to deviancy or anti-social behavior.

Speech and Language Impairment- one or more speech/language disorders of voice, articulation, rhythm and/or the receptive and expressive processes of language.

Visual Disability - A person with visual disability (Impairment) is one who has impairment of visual functioning even after treatment and/or standard refractive correction, and has visual acuity in the better eye of less than (6/18 for low vision and 3/60 for blind), or a visual field of less than10 degrees from the point of fixation. A certain level of visual impairment is defined as legal blindness. One is legally blind when your best corrected central visual acuity in your better eye is 6/60 on worse or your side vision is 20 degrees or less in the better eye.

Cancer (RA 11215) - *Cancer* refers to a genetic term for a large group of diseases that can affect anypartofthebody.Othertermsusedaremalignanttumorsandneoplasms.Onedefiningfeature of cancer is the rapid creation of abnormal cells that grow beyond their usual boundaries, and which can then invade adjoining parts of the body and spread to other organs;

Rare Disease (RA10747) - refers to disorders such as inherited metabolic disorders and other diseases with similar rare occurrence as recognized by the DOH upon recommendation of the NIH but excluding catastrophic (i.e., life threatening, seriously debilitating, or serious and chronic) forms of more frequently occurring diseases.

THIS IS ONLY A GUIDE / SAMPLE

CERTIFICATION ON DISABILITY

(In Physician's Prescription Pad)

PLEASE PUT IN LOGO OF MEDICAL HOSPITAL / CLINIC / OFFICE

This is to certify that _____(Patient's Name)_____ resident of _____(Caloocan Residence)_____, had voluntarily submitted herself/himself to this facility/clinic/office to with regard to the nature of disability.

Based on the personal interview and medical assessment conducted by herein physician, the patient has _____(Diagnose)_____ that resulted to:

- **o Deaf / Hard of Hearing**
- **o Intellectual Disability**
- **o Mental Disability**
- **o Physical Disability (Orthopedic)**
- **o Learning Disability**
- **o Psychosocial Disability**
- **o Speech and Language Impairment**
- **o Visual Disability**
- **o Cancer (RA 11215)**
- **o Rare Disease (RA 10747)**

As classified by the Department of Health Administrative Order No. 2009-011.

This Certification is issued on _____ at _____ in Compliance with the requirement in the issuance of ID for the twenty percent (20%) discount for Person with Disabilities mandated by Republic Act. No 9442 or Magna Carta for Person with Disabilities.

Signed By:
Contact No.:

Name of Physician:
License No.:

APPLICATION AND ID ARE NOT FOR SALE