Date: _____

CERTIFICATION ON DISABLITITY

This is to certify that _____ , resident of _____ , had voluntary submitted himself / herself to this facility / clinic / office with regard to the nature of disability due to the functional limitation currently experienced by the herein patient.

Based on the personal interview and medical assessment conducted by herein, the patient has the Following:

( ) Communication disability (includes impairment in speech , articulation , rhythm or totally hearing)

( ) Learning Disability – (psychological processes of disorder in the perception , comprehension and thinking)

( ) VISUAL Disability (consider NCDA resolution-refractive correction has visual acuity in the better eye of less than 6/18 low vision / and 3/60 for the blind).

( ) Intellectual Disability – (a disability resulting from organic brain syndrome (mental retardation , acquire lesions of the central nervous system , dementia and or non-psychotic disorder.)

( ) Orthopedic Disability – (is the disorder in the normal functioning of the joints , limbs and muscles.)

( ) Mental / Psychosocial Disability – (cognitive , behavioral or social impairments affect his/her daily living such as but not limited to deviancy anti-social behavior.)

( ) Chronic with disability – (inability to walk , see , speech and to do activities of daily living and can't participate in social activities due to resulting her/his to disability)

Person with disability as classified by the Department of Health Administrative Order No. 2009-011

Remarks:

_____

_____

_____

_____

This certification is issued on _____ at _____ in compliance with the requirement in the issuance of I.D for the twenty percent (20%) discount for Persons with Disabilities mandated by Republic Act No.9442 or Magna Carta for Persons with Disabilities.'

Signed:

_____

Name of Physician

License Number _____