DEPARTMENT OF HEALTH

Philippine Registry For Persons with Disabilities Version 4.0

Application Form

1. O NEWAPPLICANT	ORENEWAL *			*Place 1"x1" Photo Here*
2. PERSONS WITH DISABILITY NUMBER (RR-PPMM-BBB-NNNNNNN) *		3. Date Applied *(mm/dd/yyyy)		
im4. PERSONAL INFORMATION *				
LAST NAME: *	FIRST NAME: *	MIDDLE NAME: *	SUFFIX: *	
5. DATE OF BIRTH: * (mm/dd/yyyy)		6. SEX: * O FEMALE	O MALE	

7. CIVIL STATUS: *

OSingle OSeparated OCohabitation(live-in) OMarried OWidow/er

8. TYPE OF DISABILITY: *

- ☐ Deaf or Hard of Hearing
- ☐ Intellectual Disability
- ☐ Learning Disability
- ☐ Mental Disability
- ☐ Physical Disability (Orthopedic)
- ☐ Psychosocial Disability
- ☐ Speech and Language Impairment
- ☐ Visual Disability
- ☐ Cancer(RA11215)
- ☐ Rare Disease(RA10747)

9. CAUSE OF DISABILITY: *

☐ **Congenital/Inborn**
- ☐ Autism
- ☐ ADHD
- ☐ Cerebral Palsy
- ☐ Down Syndrome

☐ **Acquired**
- ☐ Chronic Illness
- ☐ Cerebral Palsy
- ☐ Injury

10. RESIDENCE ADDRESS *

House No. and Street:*	Barangay:*	Municipality:*	Province:*	Region:*

11. CONTACT DETAILS

Landline No.:	Mobile No.:	E-mail Address:

12. EDUCATIONAL ATTAINMENT: *

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

13. STATUS OF EMPLOYMENT: *

- O Employed
- O Unemployed
- O Self-employed

13 a. CATEGORY OF EMPLOYMENT: *

- O Government
- O Private

13 b. TYPES OF EMPLOYMENT: *

- O Permanent /Regular
- O Seasonal
- O Casual
- O Emergency

14. OCCUPATION:*

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

15. ORGANIZATION INFORMATION:

Organization Affiliated:	Contact Person:	Office Address:	Tel. Nos.:

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:			
GAUARDIAN:			

18. ACCOMPLISHED BY: *	LAST NAME	FIRST NAME	MIDDLE NAME
O APPLICANT			
O GUARDIAN			
O REPRESENTATTIVE			
19. NAME OF CERTIFYING PHYSICIAN: *LICENSE. NO.:*			
20. PROCESSING OFFICER: *			
21. APPROVING OFFICER: *			
22. ENCODER *			

23. NAME OF REPORTING UNIT: (OFFICE/SECTION)*

24. CONTROL NO.: *

IN CASE OF EMERGENCY

NAME:_____

CONTACT NO: _____

ADDRESS:_____

_____

THUMBMARK/SIGNATURE

CERTIFICATE OF APPARENT DISABILITY

Based on the personal interview and assessment conducted by the undersigned during the processing of application for PWD-IDC, the applicant _____, a residence of _____is found to have apparent

- ☐ Orthopedic Disability
- ☐ Physical Disability
- ☐ Speech and Language Impairment
- ☐ Visual Disability

As classified by the Department of Health Administrative Order No. _____.

This certification is issued on _____ at _____ with the requirement in the issuance of PWD-IDC for the benefits and privileges of person with disabilities as mandated by Republic Act No.s 9442, 10754, 11215, 10747 and related laws.

Prepared by:

_____
Processing Officer

Approved by:

_____