



**DEPARTMENT OF HEALTH**  
**Philippine Registry For Persons with Disabilities Version 4.0**  
**Application Form**

1. <input type="radio"/> NEW APPLICANT		<input type="radio"/> RENEWAL *		<input type="radio"/> LOST		<i>Place 1"x1" Photo Here</i>	
2. PERSONS WITH DISABILITY NUMBER (RR-PPMM-BBB-NNNNNNN) *				3. Date Applied *(mm/dd/yyyy)			
4. PERSONAL INFORMATION							
LAST NAME: *		FIRST NAME: *		MIDDLE NAME: *		SUFFIX: *	
5. DATE OF BIRTH: *(mm/dd/yyyy)				6. SEX: *		BLOOD TYPE:	
<input type="radio"/> FEMALE		<input type="radio"/> MALE					
7. CIVIL STATUS: *							
<input type="radio"/> Single		<input type="radio"/> Separated		<input type="radio"/> Cohabitation (live-in)		<input type="radio"/> Married	
<input type="radio"/> Widow/er							
8. TYPE OF DISABILITY: *				9. CAUSE OF DISABILITY: *			
<input type="checkbox"/> Deaf or Hard of Hearing		<input type="checkbox"/> Psychosocial Disability		<input type="checkbox"/> Congenital / Inborn		<input type="checkbox"/> Acquired	
<input type="checkbox"/> Intellectual Disability		<input type="checkbox"/> Speech and Language Impairment		<input type="checkbox"/> Autism		<input type="checkbox"/> Chronic Illness	
<input type="checkbox"/> Learning Disability		<input type="checkbox"/> Visual Disability		<input type="checkbox"/> ADHD		<input type="checkbox"/> Cerebral Palsy	
<input type="checkbox"/> Mental Disability		<input type="checkbox"/> Cancer (RA11215)		<input type="checkbox"/> Cerebral Palsy		<input type="checkbox"/> Injury	
<input type="checkbox"/> Physical Disability (Orthopedic)		<input type="checkbox"/> Rare Disease (RA10747)		<input type="checkbox"/> Down Syndrome			
10. RESIDENCE ADDRESS:							
11. CONTACT DETAILS							
Landline No.:		Mobile No.:		E-mail Address:			
12. EDUCATIONAL ATTAINMENT: *				14. OCCUPATION: *			
<input type="radio"/> None		<input type="radio"/> Senior High School		<input type="radio"/> Managers			
<input type="radio"/> Kindergarten		<input type="radio"/> College		<input type="radio"/> Professionals			
<input type="radio"/> Elementary		<input type="radio"/> Vocational		<input type="radio"/> Technicians and Associate Professionals			
<input type="radio"/> Junior High School		<input type="radio"/> Post Graduate		<input type="radio"/> Clerical Support Workers			
13. STATUS OF EMPLOYMENT: *				13 b. TYPES OF EMPLOYMENT: *			
<input type="radio"/> Employed		<input type="radio"/> Unemployed		<input type="radio"/> Permanent / Regular			
<input type="radio"/> Self-employed				<input type="radio"/> Seasonal			
				<input type="radio"/> Casual			
				<input type="radio"/> Emergency			
13 a. CATEGORY OF EMPLOYMENT: *							
<input type="radio"/> Government							
<input type="radio"/> Private							
15. IN CASE OF EMERGENCY							
Contact Person:		Contact Nos.		RELATIONSHIP			
16. ID REFERENCE NO.:							
SSS NO.:		GSIS NO.:		PAG-IBIG NO.:		PSN NO.:	
PhilHealth NO.:							
17. FAMILY BACKGROUND:							
FATHER'S NAME		LAST NAME		FIRST NAME		MIDDLE NAME	
MOTHER'S NAME:							
GUARDIAN:							
18. ACCOMPLISHED BY: *		LAST NAME		FIRST NAME		MIDDLE NAME	
<input type="radio"/> APPLICANT							
<input type="radio"/> GUARDIAN							
<input type="radio"/> REPRESENTATIVE							
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.:							

**LIST OF REQUIREMENTS**

- Certificate of Disability (Apparent/Non-Apparent) from **GOVERNMENT DOCTOR**
- Two "1x1" recent ID pictures with the name, and signature or thumbmark at the back of the picture.
- One valid government ID with **IMUS ADDRESS**
  - For children, school ID will be accepted, in the absence of school ID, a photocopy of the Birth Certificate will be required and I.D. of parent/guardian.
  - For applicant of legal age with no valid government ID, a Barangay Certificate indicating Name and Complete Address will be required.
- Proof of Residence (Utility bill/SOA)

**For guardian/representative:**

- Guardian, proof of guardianship
- Notarized Authorization Letter
- Photocopy of valid government I.D. of authorized representative

**For renewal or revalidation transactions, submission of additional documents below are required:**

- Accomplished PWDID-AF (Renewal box checked)
- Expired PWD-IDC
- Affidavit of Loss if PWD-IDC is declared lost.
- In the absence of expired PWD-IDC, two "1x1" recent ID pictures with the name, and signature or thumbmark at the back.

## CERTIFICATE OF DISABILITY

This is to certify that \_\_\_\_\_ resident of \_\_\_\_\_, had voluntarily submitted herself/himself to this facility/clinic/office with regard to the nature of disability.

Based on the personal interview and assessment conducted by herein physician, the patient has \_\_\_\_\_ that resulted to

*(medical condition)*

- Deaf/Hard of Hearing
- Intellectual Disability
- Learning Disability
- Mental Disability
- Psychosocial Disability
- Speech and Language Impairment
- Visual Disability
- Physical Disability
- Cancer (RA 11215)
- 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 PWD-IDC for the benefits and privileges of persons with disabilities as mandated by Republic Act Nos. 9442, 10754, 11215, 10747 and related laws.

Signed:

\_\_\_\_\_  
*Name and Signature of Physician*

Specialization: \_\_\_\_\_

License Number: \_\_\_\_\_

Contact number: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

**NOTE: For verification purposes, kindly attach a relevant copy of the recent medical records.**

You wish to have more information, reach us at:

Email Address: [cityofimuspdo@gmail.com](mailto:cityofimuspdo@gmail.com)

Official Facebook Page: [PDAO City of Imus](#)

Trunk Line: **(046) 888-9910 Local 138**

Cellphone Number: **0976-259-4235**

**We are open Monday to Friday, 8 am to 5 pm**