

CITY OF ILOILO

Persons with Disability Affairs Office

1st Floor, Iloilo City Hall, Plaza Libertad, Iloilo City, 5000 Philippines, Tel. No. (033) 333-1111 Loc 111



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

<input type="checkbox"/> NEW APPLICANT		<input type="checkbox"/> RENEWAL *		<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: *		<input type="checkbox"/> FEMALE
<input type="checkbox"/> MALE					
7. CIVIL STATUS: *					
<input type="radio"/> Single		<input type="checkbox"/> Separated		<input type="checkbox"/> Cohabitation (live-in)	
<input type="checkbox"/> Married		<input type="checkbox"/> 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"/> Intellectual Disability		<input type="checkbox"/> Speech and Language Impairment		<input type="checkbox"/> Acquired	
<input type="checkbox"/> Learning Disability		<input type="checkbox"/> Visual Disability		<input type="checkbox"/> Autism	
<input type="checkbox"/> Mental Disability		<input type="checkbox"/> Cancer (RA11215)		<input type="checkbox"/> ADHD	
<input type="checkbox"/> Physical Disability (Orthopedic)		<input type="checkbox"/> Rare Disease (RA10747)		<input type="checkbox"/> Cerebral Palsy	
				<input type="checkbox"/> Chronic Illness	
				<input type="checkbox"/> Injury	
				<input type="checkbox"/> Down Syndrome	
10. RESIDENCE ADDRESS *					
House No. and Street: *		Barangay: *	Municipality: *	Province: *	Region: *
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"/> Permanent / Regular		<input type="radio"/> Service and Sales Workers	
<input type="radio"/> Unemployed		<input type="radio"/> Seasonal		<input type="radio"/> Skilled Agricultural, Forestry and Fishery Workers	
<input type="radio"/> Self-employed		<input type="radio"/> Casual		<input type="radio"/> Craft and Related Trade Workers	
				<input type="radio"/> Plant and Machine Operators and Assemblers	
				<input type="radio"/> Elementary Occupations	
				<input type="radio"/> Armed Forces Occupations	
				<input type="radio"/> 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
<input type="checkbox"/> APPLICANT					
<input type="checkbox"/> GUARDIAN					
<input type="checkbox"/> 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.: *					

Revised as of August 1, 2021

 APPLICANT'S SIGNATURE