DEPARTMENT OF HEALTH

Philippine Registry For Persons with Disabilities Version 4.0

Application Form

1. ☐ NEW APPLICANT ☐ RENEWAL *				*Place 1"x1" Photo Here*
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: * ☐ FEMALE	☐ MALE	

7. CIVIL STATUS: *

○ Single ○ Separated ○ Cohabitation (live-in) ○ Married ○ Widow/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: *

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

13. STATUS OF EMPLOYMENT: *

- ○ Employed
- ○ Unemployed
- ○ Self-employed

13 a. CATEGORY OF EMPLOYMENT: *

- ○ Government
- ○ Private

13 b. TYPES OF EMPLOYMENT: *

- ○ Permanent / Regular
- ○ Seasonal
- ○ Casual
- ○ Emergency

14. OCCUPATION: *

- ○ Managers
- ○ Professionals
- ○ Technicians and Associate Professionals
- ○ 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 Occupations
- ○ 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
☐ *APPLICANT*			
☐ *GUARDIAN*			
☐ *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.: *

Pumapayag ako sa pagkolekta ng PDAO sa aking mga data at impormasyon at alam kong tanging sa PDAO at sa pangulo ng PWD sa aking barangay lamang maipapamahagi ang aking mga impormasyon. Naiintindihan kong mapoprotektahan pa rin ang aking mga karapatan ayon sa Data Privacy Act of 2012

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Signature over Printed Name of PWD or guardian

Revised as of August 1, 2021