



APPLICATION FORM:

PERSON WITH DISABILITY (PWD) IDENTIFICATION CARD

REGISTRATION NO.:1411		DATE:		
LAST NAME:		FIRST NAME:		
MIDDLE NAME:				
TYPE OF DISABILITY (Please check) <input type="checkbox"/> VISUAL DISABILITY <input type="checkbox"/> Total <input type="checkbox"/> Partial <input type="checkbox"/> COMMUNICATION DISABILITY <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Speech <input type="checkbox"/> ORTHOPEDIC DISABILITY <input type="checkbox"/> INTELLECTUAL DISABILITY <input type="checkbox"/> LEARNING DISABILITY <input type="checkbox"/> MENTAL DISABILITY <input type="checkbox"/> PSYCHOSOCIAL DISABILITY	CITY ADDRESS:			
	PROVINCIAL ADDRESS:			
	DATE OF BIRTH:		PLACE OF BIRTH:	
	SEX (Please check): <input type="checkbox"/> Male <input type="checkbox"/> Female		CONTACT NUMBER:	
	NATIONALITY:		BLOOD TYPE:	
	CIVIL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widow/er <input type="checkbox"/> Co-Habitation			
	EDUCATIONAL ATTAINMENT: (Please check one) <input type="checkbox"/> Elementary Graduate <input type="checkbox"/> Elementary Undergraduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> High School Undergraduate <input type="checkbox"/> College Graduate <input type="checkbox"/> College Undergraduate <input type="checkbox"/> Post- Graduate <input type="checkbox"/> Vocational Graduate <input type="checkbox"/> Non-Formal Education			
	CAUSE OF DISABILITY: <input type="checkbox"/> Inborn <input type="checkbox"/> Illness/ Disease: _____ <input type="checkbox"/> Injury Related <input type="checkbox"/> Armed-Conflict <input type="checkbox"/> Accident <input type="checkbox"/> Environmental Cause			
	SPECIAL LITERACY SKILLS: <input type="checkbox"/> Braille <input type="checkbox"/> Sign Language <input type="checkbox"/> Lip Reading <input type="checkbox"/> Oral Communication Other skills: _____			
	EMPLOYMENT STATUS: (Please check one) <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Displaced Worker <input type="checkbox"/> Resigned <input type="checkbox"/> Retired <input type="checkbox"/> Returning OFW		NATURE OF EMPLOYER: (Please check one) <input type="checkbox"/> Private <input type="checkbox"/> Government	
TYPE OF EMPLOYMENT: <input type="checkbox"/> Contractual <input type="checkbox"/> Permanent <input type="checkbox"/> Self-Employed <input type="checkbox"/> Seasonal		OCCUPATION: <input type="checkbox"/> Officials of Government and Special Interest Orgs., Executives, Managers, Supervisors, Managing Proprietors <input type="checkbox"/> Professionals <input type="checkbox"/> Plant and Machine Operators <input type="checkbox"/> Technicians and Associate Professionals <input type="checkbox"/> Laborers <input type="checkbox"/> Clerks <input type="checkbox"/> Unskilled Workers <input type="checkbox"/> Service Workers, Shops and Market Sales <input type="checkbox"/> Not Applicable <input type="checkbox"/> Farmers, Forestry Workers, Fishermen <input type="checkbox"/> Others: _____ <input type="checkbox"/> Trades and Related Workers		
ID Reference No. SSS ID No. _____ GSIS ID No. _____ Philhealth No. _____ <input type="checkbox"/> Philhealth Member <input type="checkbox"/> Philhealth Dependent				
ORGANIZATION AFFILIATION: Organization Affiliated: _____ Contact Person: _____ Office Address: _____				
	LAST NAME	FIRST NAME	MIDDLE NAME	CONTACT NUMBER
FATHER'S NAME				
MOTHER'S NAME				
CONTACT PERSON IN CASE OF EMERGENCY				
I hereby certify that the above statements are true and correct to the best of my knowledge and belief. _____ Signature/ Thumb mark of Applicant			Processed by: _____ Noted by: BETTY F. FANGASAN City Social Welfare and Dev't Officer	

REQUIREMENTS:

- Duly Accomplishment Form
- Photocopy of Medical Certificate specifying the disability of applicant
- 2 copies 1x1 ID Picture
- Barangay Residency Certificate

NOTE: Chronic Illness is not a disability, rather a medical condition. To qualify for the 20% PWD discount, there should be a disability resulting from the chronic illness (For example, visual disability due to diabetes, orthopedic disability due to cancer).