PHILIPPINE MEDICAL ASSOCIATION

MEMORANDUM CIRCULAR NO: 2018-08-20-019

TO: ALL COMPONENT MEDICAL SOCIETIES, SPECIALTY DIVISIONS, SPECIALTY AND AFFILIATE SOCIETIES

SUBJECT: MUTUAL AID DISABILITY NOTIFICATION FORM

DATE: AUGUST 20, 2018

Greetings from the Philippine Medical Association!

Upon recommendation of the Commission on Mutual Aid through its Chairman, Dr. Enrico C. Ignacio, the PMA Board of Governors during its meeting held August 18, 2018 has approved the Disability Notification Form. This will be submitted to PMA by the members through their component societies once they claim for disability benefit.

A downloadable form will likewise be posted in the PMA Website.

Very truly yours,

BENJAMIN M. ALABAN, MD
Secretary General

Noted:

JOSE P. SANTIAGO, JR., MD
President

/cvs
**PHILIPPINE MEDICAL ASSOCIATION**  
Commission On Mutual Aid  
**DISABILITY NOTIFICATION FORM**

### PMA MEMBER's NOTIFICATION

<table>
<thead>
<tr>
<th>Name of Member:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>PRC Number:</td>
</tr>
<tr>
<td>Contact Number:</td>
<td>PMA Number:</td>
</tr>
<tr>
<td>Email Address:</td>
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</tbody>
</table>

This is to inform PMA that I am/was confined/indisposed on the dates indicated herein. I certify that I consent to release the following medical information as provided for by my attending physician and other attending doctors as I request for my disability benefits from the PMA.

PMA Member's Printed Name and Signature:

### ATTENDING PHYSICIAN'S CERTIFICATION

(To be filled by the Attending Physician)

<table>
<thead>
<tr>
<th>Date Examined/ Attended</th>
<th>Number of Days of Confinement:</th>
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</table>

Place of Confinement:

**Diagnosis:**

- [ ] Vision Impairment.
- [ ] Deafness/hearing impairment.
- [ ] Mental health impairment.
- [ ] Acquired brain injury.
- [ ] Physical disability.
- [ ] Others: Specify: e.g. Cancer

**Nature of Disability:**

Nature of Treatment/Treatment Required:

- [ ] Medical Management
- [ ] Surgery
- [ ] Chemotherapy
- [ ] Immunotherapy
- [ ] Radiation Therapy
- [ ] Rehabilitation Services
- [ ] Others: Specify:

**Duration of Disability:**

**Duration of Treatment:**

Will be fit to resume clinic/hospital practice on:

**Course of Disability:** Course of illness upon discharge from the hospital (Please use extra sheet if necessary):

Printed Name and Signature of Attending Physician:

Clinic Address:

License Number:

Contact Number:

### COMPONENT SOCIETY ENDORSEMENT

Date Received:

Checked by (Printed Name and Signature):

Endorsed by (Printed Name and Signature):

Component Society:
SPECIFIC GUIDELINES FOR PERMANENT TOTAL AND PERMANENT PARTIAL DISABILITY

1. Permanent Total Disability – means complete incapacity of the member, resulting from bodily injury or disease which wholly prevents the member permanently to practice medicine as a profession.

Included are:

- Total and irrevocable loss of sight of both eyes
- Loss of 2 or more limbs by amputation at or above the wrists or ankles
- Loss of sight in one eye, loss of one limb by amputation at or above the wrist or ankle
- Chronic/Acute organ failure – secondary to an irreversible underlying disease with poor prognosis within 2 years
- Diseases of the brain with severe damage associated with permanent neurological deficit or loss of brain function

2. Permanent Partial Disability – means complete incapacity to practice medicine as a profession because of bodily injury or disease uninterruptedly beyond 60 days.

Included are:

- Loss of one limb by amputation at or above the wrist or ankle
- Total and irrevocable loss of all sight in one eye
- Loss of thumb or index finger or either hand at or above the metacarpophalangeal joints
- Injury, disease or illness with chronic and progressive course causing physical/mental incapacity with poor prognosis beyond 2 years
- Brain disease with neurological deficits and loss of functions reversible beyond 60 days
- Vital organ failure, reversible beyond 60 days