PHILIPPINE MEDICAL ASSOCIATION
Commission On Mutual Aid
DISABILITY NOTIFICATION FORM

PMA MEMBER's NOTIFICATION

Name of Member:	Age:	Date:
Address:		PRC Number:
Contact Number:		PMA Number:
Email Address:		

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) Date: _____

THIS IS TO CERTIFY THAT I HAVE EXAMINED AND/OR ATTENDED TO THE ABOVE-NAMED PMA MEMBER WITH THE FOLLOWING DETAILS:

Date Examined/ Attended		Number of Days of Confinement:	
Place of Confinement:			
Diagnosis:			
Nature of Disability: ☐ Vision Impairment. ☐ Deafness/hearing impairment. ☐ Mental health impairment ☐ Acquired brain Injury ☐ Physical disability ☐ Others: Specify: e.g. Cancer _____	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: