ANNEX 4

LOGO OF MEDICAL HOSPITAL, CLINIC OR OFFICE

CERTIFICATE OF NON-APPARENT DISABILITY

This is to certify that (______ name ______), resident of (__________________ address __________________), had voluntarily submitted herself/himself to this facility/clinic/office with regard to the nature of disability.

Based on the personal interview and assessment conducted by herein physician, the patient has (___ medical condition ___) that resulted to

- ☐ Deaf/Hard of Hearing
- ☐ Intellectual Disability
- ☐ Learning Disability
- ☐ Mental Disability
- ☐ Psychosocial Disability
- ☐ Speech and Language Impairment
- ☐ Visual Disability

as classified by the Department of Health Administrative Order No. XXXX-XXXX.

This certification is issued on (date) at (place) in compliance with the requirement *in* the issuance of PWD-IDC for the benefits and privileges of persons with disabilities as mandated by Republic Act. No. 9442 and related laws.

Signed:

____

Name of Physician

License number__________