(logo of clinic or hospital)

**CERTIFICATION ON DISABILITY**

This is to certify that (your name), resident of (your full address) in the (province and region) had voluntarily submitted himself to this facility with regard to the nature of the disability due to the functional limitation currently experienced by the herein patient.

Based on the personal interview and medical assessment conducted by herein physician, the patient has (diagnosis) accompanied by (describe the health condition) which results to difficulty in (e.g. walking, seeing, etc) and therefore considered as a person with (mention the type of disability) as classified by the Department of Health Administrative Order No. 2009-011.

This certification is issued on (date) at (place) iin compliance with the requirement in the issuance of ID for the twenty percent (20%) discount for Persons with Disabilities mandated by Republic Act No. 9442 or Magna Carta for Persons with Disabilities.

Signed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
(physician’s name)

(license number)