UNIVERSITY OF THE PHILIPPINES
DILIMAN **QUEZON CITY**
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OFFICE OF THE CHANCELLOR E-MAIL: chancellor.updiliman@up.edu.ph

14 December 2020

MEMORANDUM NO. FRN-20-083

TO : Deans, Directors, Head of Units

SUBJECT : **Mass Testing for SARS Cov2**

The unprecedented public health threat posed by the coronavirus pandemic has been with us for almost a year now. Community quarantine measures implemented especially in the National Capital Region which drastically altered the way we conduct our daily activities, including work have been continuously in place for more than nine months.

While the number of new cases of SARS Cov 2 has not dwindled to a low enough number to warrant a return to normal conditions, recent DOH data show that the positivity rate (the proportion testing positive among cases tested) has been decreasing. Moreover, the effective reproduction number (Rt) in the NCR, according to the latest estimate using DOH publicly released data is now below 1 (Cayton, 2020). Furthermore, RT-PCR testing, considered the gold standard for detecting infection has become more easily available and turn-around time for test results considerably shortened compared to the early months of the lockdown. The Philippine Genome Center (PGC) located within the UP Diliman campus is a major testing laboratory.

Given all these developments, UP Diliman is now in the process of crafting new policies and procedures for reopening work in the physical offices within the campus to replace the current 2-day physical presence of a skeleton work force and work-from-home arrangements for others. While normal pre-pandemic work arrangements are not expected to resume within the foreseeable future, it is recognized by the UP Diliman administration that some changes to the current working conditions will need to be instituted given the improvement in the status of the epidemic in the NCR.

Still, the threat of the virus remains. Thus in the design of new work arrangements, the administration should be informed by an understanding of the status of SARS Cov 2 infection in the UP Diliman work force through mass screening/testing to be conducted by the PGC with assistance from the University Health Service. The PGC has committed to the availability of test kits for all members of the UP Diliman work force – faculty and staff, as well the non-UP workers assigned to the buildings in the campus (e.g. security guards, custodial workers) and other groups whose place of work is the UP Campus such as construction workers and ambulant vendors. The test will be conducted free of charge.

The general objective of the mass testing is to estimate the prevalence of coronavirus infection among the UP and non-UP work force of the UP Diliman Campus. Thus the mass testing will target ALL those whose place of work is the UP Campus. Testing will commence this week with front liners (e.g. UHS staff, PGC staff), security guards, custodial workers, construction workers and ambulant vendors. For the rest, the mass testing will be conducted following a schedule that will be designed by the University Health Service and disseminated to all. Testing for non-front liners will commence in January.

Procedural details for the conduct of the mass testing will be made available to all Units of the University after consultations with you or your representatives.

In this regard, please submit a list of all UP and non-UP employees within your Unit classified into:

a) employee type (faculty, academic non-teaching, administrative, UP non-contractual, Others (please specify) and,
b) reporting status (physically reporting for work or not physically reporting for work) as of December 2020

In addition, please instruct the unit's employees to fill out and submit the Case Investigation Form (CIF).

The list and the CIFs will be the basis for the UHS to prepare the testing schedule. Please submit these documents by 18 December 2020 to uhsdirectorsofc@gmail.com, uphspublichealth.upd@up.edu.ph and covid19.taskforce@upd.edu.ph. Please use the following format in your subject line:

(for LIST) Unit Name_Mass Testing LIST
(for CIFs) Unit Name_Mass Testing CIFs

Thank you.

FIDEL R. NEMENZO, D.Sc.
Chancellor

Attachments:

Case Investigation Form (CIF)
Appendix 1 & 2 of the CIF
PhilHealth Member Registration Form (to be submitted by those who do not have PhilHealth numbers)

Philippine Integrated Disease Surveillance and Response

Case Investigation Form
Coronavirus Disease (COVID-19)
Version 7

General Instructions:

1. The Case Investigation Form is meant to be administered as an Interview by a health care worker or any personnel of the Disease Reporting Unit. **This is not a Self-Administered Questionnaire**.
2. Please be advised that Disease Reporting Units are only allowed to obtain **1 copy of accomplished CIF** from a patient.
3. Please fill out all blanks and put a check mark on the appropriate box. Never leave an item blank, just write N/A or not applicable. **Items with * are required fields.**
4. All dates must be in **MM/DD/YYYY format.**

Disease Reporting Unit*	**DRU Region and Province**	**PhilHealth No.***
UP HEALTH SERVICE	NATIONAL CAPITAL REGION	
Name of Interviewer	**Contact Number of Interviewer**	**Date of Interview (MM/DD/YYYY)***
DR. ALIZA M. PANGAIBAT	89818500 LOCAL 111	
Name of Informant (If patient unavailable)	**Relationship**	**Contact Number of Informant**

Type of Client

☐ COVID-19 Case (Suspect, Probable, or Confirmed) ☐ Close Contact
☐ For RT-PCR Testing (Not a Case of Close Contact) ☐ Others, please specify: _____

1. Testing Category/Subgroup (Check all that apply) *Refer to Appendix 1*

☐ A	☐ B	☐ C	☐ D	☐ E	☐ F	☐ G	☐ H	☐ I	☐ J

Part 1. Patient Information

2. Patient Profile

Last Name*	First Name (and Suffix)*	Middle Name*
Birthday (MM/DD/YYYY)*	Age*	Sex* Male Female
Civil Status	Nationality	Occupation
Specific Occupation	Status of employment in UP	Reporting Status
☐ Faculty ☐ REPS ☐ Staff ☐ Health worker ☐ Custodial worker (Agency) ☐ Security Guard ☐ Construction worker ☐ Ambulant vendor	☐ UP Permanent ☐ UP Contractual ☐ Non-UP Contractual ☐ Agency Hire ☐ Job Order/ Project based/ Contract of Service	☐ Fully work from home ☐ Partial work from home with a regular schedule (physically reporting at least once a week) ☐ Partial work from home with irregular schedule (physically reporting on a non-regular schedule, WFH rest of the time) ☐ Others, please specify: _____

3. Current Address in the Philippines and Contact Information* (Give address of institution if you live in closed settings, see Part 2 #9)

House No./Lot/Bldg.	Street/Purok/Sitio	Barangay	Municipality/City

Province	Home Phone No. (& Area Code)	Cellphone No.	Email Address

4. Current Workplace Address and Contact Information (Indicate Department, Office and Unit)

Lot/Bldg.	Street	Barangay	Municipality/City
Province	**Name of Workplace**	**Phone No./ Cellphone No.**	**Email Address**

5. Consultation and Admission Information

Did you have previous COVID-19 related consultation?	☐ Yes, Date of First Consult(MM/DD/YYYY)* _____ ☐ No
Name of facility where first consult was done	
Was the case admitted in a health facility?	☐ Yes, Date of Admission (MM/DD/YYYY)* *Indicate earliest date if admitted in multiple health facilities* _____ ☐ No
Name of Facility where patient was first admitted	
Region and Province of Facility	

6. Disposition at Time of Report* (Provide name of hospital/isolation/quarantine facility)

Admitted in hospital _____ Date and Time admitted in hospital _____
Admitted in isolation/quarantine facility _____ Date and Time isolated/quarantined in facility _____
In home isolation/quarantine Date and Time isolated/quarantined at home _____
Discharged to home If Discharged: Date of Discharge (MM/DD/YYYY)* _____ Others: _____

7. Health Status at Consult*

☐ Asymptomatic ☐ Mild ☐ Moderate ☐ Severe ☐ Critical

8. Case Classification* ***(Refer to Appendix 2)***

☐ Suspect ☐ Probable ☐ Confirmed ☐ Non-COVID-19 Case

PART 2: Case Investigation Details

9. Special Population

Health Care Worker*	Yes, Name & location of health facility _____	No
Returning Overseas Filipino*	Yes, Country of origin _____	No
Foreign National Traveler*	Yes, Country of origin _____	No
Locally Stranded Individual/APOR/Traveler*	Yes, City, Mun, & Prov of origin _____	No
Lives in Closed Settings*	Yes, specify Type of Institution (e.g. prisons, residential facilities, retirement communities, care homes, camps etc.) _____ and specify Name of Institution _____	No

10. Permanent Address and Contact Information (If different from current address)

House No./Lot/Bldg.	Street /Purok/Sitio	Barangay	Municipality/City
Province	Home Phone No. (& Area Code)	Cellphone No.	Email Address

11. Address Outside the Philippines and Contact Information (for Overseas Filipino Workers and Individuals with Residence outside PH)

House No./Lot/Bldg.	Street	Municipality/City	Province
Country	Place of Work	Employer's Name	Employer's/Office Contact No.

12. Clinical Information

Date of Onset of Illness (MM/DD/YYYY)*
_____

Signs and Symptoms (Check all that apply if present)

☐ Asymptomatic
☐ Fever _____ °C
☐ Cough
☐ General weakness
☐ Fatigue
☐ Headache
☐ Myalgia
☐ Sore throat
☐ Coryza
☐ Dyspnea
☐ Anorexia
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Altered Mental Status
☐ Anosmia (loss of smell)
☐ Ageusia (loss of taste)
☐ Others _____

Comorbidities (Check all that apply if present)

☐ None
☐ Hypertension
☐ Diabetes
☐ Heart Disease
☐ Lung Disease
☐ Gastrointestinal
☐ Genito-urinary
☐ Neurological Disease
☐ Cancer
☐ Others _____

Are you pregnant?
☐ Yes, LMP _____
☐ No

High-risk pregnancy?
☐ Yes
☐ No

Were you diagnosed to have Severe Acute Respiratory Illness? *(Refer to Appendix 2)* ☐ Yes ☐ No

Chest imaging findings suggestive of COVID-19

Imaging Done (Check all that apply)	Results
☐ Chest radiography	Normal Hazy opacities, often rounded in morphology, with peripheral and lower lung distribution Pending Other findings, specify _____

☐ Chest CT	Normal	Multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution
	Pending	Other findings, specify _____
☐ Lung ultrasound	Normal	Thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidative patterns with or without air bronchograms.
	Pending	Other findings, specify _____

☐ None

13. Laboratory Information

Test Done* (Check all that apply)	Date Collected*	Laboratory	Results*	Date Released
☐ RT-PCR (OPS)			Pending Positive Negative Equivocal	
☐ RT-PCR (NPS)			Pending Positive Negative Equivocal	
☐ RT-PCR (OPS and NPS)			Pending Positive Negative Equivocal	
☐ RT-PCR (specimen type _____)			Pending Positive Negative Equivocal	
☐ Antigen Test			Pending Positive Negative Equivocal	
☐ Antibody Test			IgM (+) IgG (-) IgG (+) IgM (-) IgM (+) IgG (+) IgM (-) IgG (-)	
☐ Others _____			Specify Result:	

Have you ever tested positive using RT-PCR before? ☐ Yes, Date of Specimen Collection (MM/DD/YYYY)* _____ ☐ No
If Yes, Laboratory _____ Number of previous RT-PCR swabs done _____

14. Outcome/Condition at Time of Report*

Active (Currently admitted or in isolation/quarantine) Recovered, Date of Recovery (MM/DD/YYYY)* _____
Died, Date of Death (MM/DD/YYYY)* _____
Cause of Death* Immediate Cause _____
Antecedent Cause _____ Underlying Cause _____

Part 3: Contact Tracing

15. Exposure History

History of exposure to known probable and/or confirmed COVID-19 case 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection?*	Yes, Date of LAST Contact (MM/DD/YYYY)*_____ No Unknown
Have you been in a place with a known COVID-19 community transmission 14 days before the onset of signs and symptoms? OR If Asymptomatic, 14 days before swabbing or specimen collection?*	Yes No Unknown exposure

If Yes, specify place (Check all that apply, provide details such as name of establishment, transport service, venue, location etc. and date of visit in MM/DD/YYYY)

Place Visited	Details	Date of Visit	Place Visited	Details	Date of Visit
Health Facility			Transportation		
Closed Settings (e.g. Jail)			Workplace		
Market			Local Travel		
Home			Social Gathering		
International Travel			Others		
School					

16. Travel History

History of travel/visit/work in other countries with a known COVID-19 transmission 14 days before the onset of signs and symptoms		Yes, Country of exit _____ No	
Airline/Sea vessel	Flight/Vessel Number	Date of Departure (MM/DD/YYYY)	Date of Arrival in PH (MM/DD/YYYY)
History of travel/visit/work in other local place with a known COVID 19 transmission 14 days before the onset of signs and symptoms		Yes, Place of origin_____ No	
Airline/Sea vessel/Bus line/Train	Flight/Vessel Number/ Bus No.	Date of Departure (MM/DD/YYYY)	Date of Arrival in the Current City/Mun (MM/DD/YYYY)

List the names of persons who were with you two days prior to onset of illness until this date and their contact numbers. *If asymptomatic, list the names of persons who were with you on the day you submitted specimen for testing until this date and their contact numbers. *(Use additional space below if needed).*	Name	Contact No.

For Additional Close Contact (Include ALL Household Contacts)

Name	Contact Number	Exposure Setting (ex. Household, Work)
1.		
2.		
3.		
4.		
5.		

6.		
7.		
8.		
9.		
10.		

Appendix 1. Testing Category/Subgroup

- **Sub-group A:** Individuals with severe/critical symptoms and relevant history of travel and/or contact
- **Sub-group B:** Individuals with mild symptoms and relevant history of travel and/or contact, and considered vulnerable. Vulnerable populations include those elderly and with preexisting medical conditions that predispose them to severe presentation and complications of COVID-19 • **Sub-group C:** Individuals with mild symptoms, and relevant history of travel and/or contact
- **Subgroup D:** Individuals with no symptoms but with relevant history of travel and/or contact or high risk of exposure. These include: o Subgroup D1: Contact-traced individuals
    - o Sub-group D2: Healthcare workers, who shall be prioritized for regular testing in order to ensure the stability of our healthcare system. o Subgroup D3: Returning Overseas Filipino Workers, who shall immediately be tested at the port of entry
    - o Subgroup D4: Filipino citizens in a specific locality within the Philippines who have expressed intention to return to their place of residence/home origin (Locally Stranded Individuals) may be tested subject to the existing protocols of the IATF.
- **Subgroup E:** Frontliners indirectly involved in health care provision in the response against COVID-19 may be tested as follows:
    - o Sub-group E1: Those with high or direct exposure to COVID-19 regardless of location may be tested up to once a week. These include the following:
        1. Personnel manning the Temporary Treatment and Quarantine Facilities (LGU and Nationally-managed);
        2. Personnel serving at the COVID-19 swabbing center;
        3. Contact tracing personnel; and
        4. Any personnel conducting swabbing for COVID-19 testing.
    - o Sub-group E2: Those who do not have high or direct exposure to COVID-19 but who live or work in Special Concern Areas may be tested up to every two to four weeks. These include the following:
        1. Personnel manning Quarantine Control Points, including those from Armed Forces of the Philippines, Bureau of Fire Protection, and others;
        2. National/Regional/Local Risk Reduction and Management Teams;
        3. Officials from any local government/city/municipality health office (CEDSU, CESU, etc.)
        4. Barangay Health Emergency Response Teams and barangay officials providing barangay border control and performing COVID-19- related tasks;
        5. Personnel of Bureau of Corrections and Bureau of Jail Penology and Management;
        6. Personnel manning the One-Stop-Shop in the Management of the Returning Overseas Filipinos;
        7. Border control or patrol officers, such as immigration officers and the Philippine Coast Guard; and
        8. Social workers providing amelioration and relief assistance to communities and performing COVID-19-related tasks.
- **Sub-group F:** Other vulnerable patients and those living in confined spaces. These include, but are not limited to:
    - o Pregnant patients who shall be tested during the peripartum period;
    - o Dialysis patients;
    - o Patients who are immunocompromised, such as those who have HIV/AIDS, inherited diseases that affect the immune system; o Patients undergoing chemotherapy or radiotherapy;
    - o Patients who will undergo elective surgical procedures with high risk for transmission;
    - o Any person who have had organ transplants, or have had bone marrow or stem cell transplant in the past 6 months;
    - o Any person who is about to be admitted in enclosed institutions such as jails, penitentiaries, and mental institutions.
- **Subgroup G:** Residents, occupants or workers in a localized area with an active COVID-19 cluster, as identified and declared by the local chief executive in accordance with existing DOH Guidelines and consistent with the National Task Force Memorandum Circular No. 02 s.2020 or the Operational Guidelines on the Application of the Zoning Containment Strategy in the Localization of the National Action Plan Against COVID-19 Response. The local chief executive shall conduct the necessary testing in order to protect the broader community and critical economic activities and to avoid a declaration of a wider community quarantine.
- **Subgroup H:** Frontliners in Tourist Zones:
    - o Sub-group H1: All workers and employees in the hospitality and tourism sectors in El Nido, Boracay, Coron, Panglao, Siargao and other tourist zones, as identified and declared by the Department of Tourism. These workers and employees may be tested once every four (4) weeks. o Sub-group H2: All travelers, whether of domestic or foreign origin, may be tested at least once, at their own expense, prior to entry into any designated tourist zone, as identified and declared by the Department of Tourism.
- **Subgroup group I:** All workers and employees of manufacturing companies and public service providers registered in economic zones located in Special Concern Areas may be tested regularly.
- **Subgroup J:** Economy Workers
    - o Sub-group J1: Frontline and Economic Priority Workers, defined as those (1) who work in high priority sectors, both public and private, (2) have high interaction with and exposure to the public, and (3) who live or work in Special Concern Areas, may be tested every three months. These workers include, but are not limited to:
        1. Transport and Logistics
        - Drivers of Taxis, Ride Hailing Services (two and four wheels), Buses, Public Transport Vehicles
        - Conductors
        - Pilots, Flight Attendants, Flight Engineers
        - Rail operators, mechanics, servicemen
        - Delivery staff
        - Water transport workers - ferries, inter island shipping, ports

2. Food Retail
    - Waiters, Waitresses, Bar Attendants, Baristas
    - Chefs and Cooks
    - Restaurant Managers and Supervisors
3. Education - once face to face classes resume
    - Teachers at all levels of education
    - Other school frontliners such as guidance counselors, librarians, cashiers
4. Financial Services
    - Bank tellers
5. Non-Food Retail
    - Cashiers
    - Stock clerks
    - Rerail salespersons
6. Services
    - Hairdressers, Barbers, Manicurist, Pedicurist, Massage Therapists
    - Embalmers, Morticians, Undertakers, Funeral Directors
    - Parking Lot Attendants
    - Security Guards
    - Messengers
    - Ushers, Lobby Attendants, Receptionist
    - Clergy
7. Market Vendors
8. Construction
    - Carpenters
    - Stonemasons
    - Electricians
    - Painters
    - Construction workers, including Foremen, Supervisors
    - Civil Engineers, Structural Engineers, Construction Managers
    - Crane and Tower operators
    - Elevator installer and repairers
9. Water Supply, Sewerage, Waste Management
    - Plumbers
    - Recycling and Reclamation worker/ Garbage Collectors
    - Water/Wastewater engineers
    - Janitors and cleaners
10. Public Sector
    - Judges
    - Courtroom clerks, staff, and security
    - All national and local government employees rendering frontline services in Special Concern Areas
11. Mass media - Field reporters, photographers, and cameramen

Appendix 2. COVID-19 Case Definitions

I. Suspect COVID-19 case (two suspect case definitions A or B):

A. A person who meets the clinical **AND** epidemiological criteria:

Clinical criteria:

1. Acute onset of fever AND cough;

OR

2. Acute onset of ANY THREE OR MORE of the following signs or symptoms: fever, cough, general weakness/fatigue[1], headache, myalgia, sore throat, coryza, dyspnoea, anorexia/nausea/vomiting, diarrhoea, altered mental status.

AND

Epidemiological criteria:

1. Residing or working in an area with high risk of transmission of the virus: for example, closed residential settings and humanitarian settings, such as camp and camp-like settings for displaced persons, any time within the 14 days prior to symptom onset;

OR

2. Residing in or travel to an area with community transmission[2] anytime within the 14 days prior to symptom onset;

OR

3. Working in health setting, including within health facilities and within households, anytime within the 14 days prior to symptom onset.

B. A patient with severe acute respiratory illness (SARI: acute respiratory infection with history of fever or measured fever of ≥ 38 C°; and cough; with onset within the last 10 days; and who requires hospitalization).

II. Probable COVID-19 case:

A. A patient who meets clinical criteria above AND is a contact of a probable or confirmed case, or epidemiologically linked to a cluster of cases which has had at least one confirmed case identified within that cluster.

B. A suspect case (described above) with chest imaging showing findings suggestive of COVID-19 disease*

* Typical chest imaging findings suggestive of COVID-19 include the following (Manna 2020):

- chest radiography: hazy opacities, often rounded in morphology, with peripheral and lower lung distribution
- chest CT: multiple bilateral ground glass opacities, often rounded in morphology, with peripheral and lower lung distribution • lung ultrasound: thickened pleural lines, B lines (multifocal, discrete, or confluent), consolidative patterns with or without air bronchograms. **C.** A person with recent onset of anosmia (loss of smell) or ageusia (loss of taste) in the absence of any other identified cause. **D.** Death, not otherwise explained, in an adult with respiratory distress preceding death AND who was a contact of a probable or confirmed case or epidemiologically linked to a cluster which has had at least one confirmed case identified within that cluster.

III. Confirmed COVID-19 case:

A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

[1] Signs separated with slash (/) are to be counted as one sign.

[2] Community transmission: Countries /territories/areas experiencing larger outbreaks of local transmission defined through an assessment of factors including, but not limited to: large numbers of cases not linkable to transmission chains, large numbers of cases from sentinel lab surveillance or increasing positive tests through sentinel samples (routine systematic testing of respiratory samples from established laboratories), multiple unrelated clusters in several areas of the country/territory/area.

PhilHealth
Your Partner in Health

PMRF

PHILHEALTH MEMBER REGISTRATION FORM
UHC v.1 January 2020

PHILHEALTH IDENTIFICATION NUMBER (PIN)

REMINDERS:

1. Your PhilHealth Identification Number (PIN) is your unique and permanent number.
2. Always use your PIN in all transactions with PhilHealth.
3. For Updating/Amendment check the appropriate box and provide details to be accomplished and submit corresponding supporting documents.
4. Please read instructions at the back before filling-out this form.

PURPOSE:
☐ REGISTRATION ☐ UPDATING/AMENDMENT

Preferred KonSulTa Provider

I. PERSONAL DETAILS

	LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME	NO MIDDLE NAME (Check if applicable only)	MONONYM
MEMBER					☐	☐
MOTHER's MAIDEN NAME					☐	☐
SPOUSE (If Married)					☐	☐

DATE OF BIRTH (m m d d y y y y)

PLACE OF BIRTH (City/Municipality/Province/Country)
(Please indicate country if born outside the Philippines)

PHILSYS ID NUMBER (Optional)

SEX
☐ Male ☐ Female

CIVIL STATUS
☐ Single ☐ Annulled ☐ Married ☐ Widow/er ☐ Legally Separated

CITIZENSHIP
☐ FILIPINO ☐ FOREIGN NATIONAL ☐ DUAL CITIZEN

TAX PAYER IDENTIFICATION NUMBER (TIN) (Optional)

II. ADDRESS and CONTACT DETAILS

PERMANENT HOME ADDRESS
Unit/Room No./Floor | Building Name | Lot/Block/Phase/House Number | Street Name

Subdivision | Barangay | Municipality/City | Province/State/Country (If abroad) | ZIP Code

MAILING ADDRESS ☐ SAME AS ABOVE
Unit/Room No./Floor | Building Name | Lot/Block/Phase/House Number | Street Name

Subdivision | Barangay | Municipality/City | Province/State/Country (If abroad) | ZIP Code

Home Phone Number
(COUNTRY CODE + AREA CODE + TELEPHONE NUMBER)

Mobile Number (Required)

Business (Direct Line)

E-mail Address (Required for OFW)

III. DECLARATION OF DEPENDENTS

(Use additional form if necessary)

LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME	RELATIONSHIP	DATE OF BIRTH (mm-dd-yyyy)	CITIZENSHIP	NO MIDDLE NAME (Check if applicable only)	MONONYM	Check if with Permanent Disability
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐

IV. MEMBER TYPE

DIRECT CONTRIBUTOR

☐ Employed Private
☐ Employed Government
☐ Professional Practitioner
☐ Self-Earning Individual
  ☐ Individual
  ☐ Sole Proprietor
  ☐ Group Enrollment Scheme
  _____
☐ Kasambahay ☐ Family Driver
☐ Migrant Worker
  ☐ Land-Based ☐ Sea-Based
☐ Lifetime Member
☐ Filipinos with Dual Citizenship / Living Abroad
☐ Foreign National
  PRA SRRV No. _____
  ACR I-Card No. _____

INDIRECT CONTRIBUTOR

☐ Listahanan ☐ LGU-sponsored
☐ 4Ps/MCCT ☐ NGA-sponsored
☐ Senior Citizen ☐ Private-sponsored
☐ PAMANA ☐ Person with Disability
☐ KIA/KIPO PWD ID No. _____
☐ Bangsamoro/Normalization

PROFESSION: (Except Employed, Lifetime Members and Sea-based Migrant Worker)

MONTHLY INCOME:

PROOF OF INCOME:

For PhilHealth Use only:
☐ Point of Service (POS) Financially Incapable
☐ Financially Incapable

Continue at the back

V. UPDATING/AMENDMENT		
Please check:	**FROM**	**TO**
☐ Change/Correction of Name (Last Name, First Name, Name Extension (Jr./Sr./III) Middle Name)		
☐ Correction of Date of Birth		
☐ Correction of Sex		
☐ Change of Civil Status		
☐ Updating of Personal Information/Address/ Telephone Number/Mobile Number/e-mail Address		

Under penalty of law, I hereby attest that the information provided, including the documents I have attached to this form, are true and accurate to the best of my knowledge. I agree and authorize PhilHealth for the subsequent validation, verification and for other data sharing purposes only under the following circumstances:

- As necessary for the proper execution of processes related to the legitimate and declared purpose;
- The use or disclosure is reasonably necessary, required or authorized by or under the law; and,
- Adequate security measures are employed to protect my information.

_____ _____

Member's Signature over Printed Name **Date**

Please affix right thumbmark if unable to write

FOR PHILHEALTH USE ONLY

RECEIVED BY:

Full Name: _____

PRO/LHIO/Branch: _____

Date & Time: _____

INSTRUCTIONS

1. All information should be written in UPPER CASE/CAPITAL LETTERS. If the information is not applicable, write "N/A."
2. All fields are mandatory unless indicated as optional. By affixing your signature, you certify the truthfulness and accuracy of all information provided.
3. A properly accomplished PMRF shall be accompanied by a valid proof of identity for first time registrants, and supporting documents to establish relationship between member and dependent/s for updating or request for amendment.
4. On the PURPOSE, check the appropriate box if for **Registration** or for **Updating/Amendment** of information.
5. Indicate preferred KonSulTa provider near the place of work or residence.
6. For PERSONAL DETAILS, all name entries should follow the format given below. Check the appropriate box if registrant has no middle name and/or with single name (mononym).

LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME
SANTOS	JUAN ANDRES	III	DELA CRUZ

7. Indicate registrant's/member's name as it appears in the birth certificate.
8. The full mother's maiden name of registrant/member must be indicated as it appears in the birth certificate.
9. Indicate the full name of spouse if registrant/member is married.
10. Indicate the complete permanent and mailing addresses and contact numbers.
11. For updating/amendment, check the appropriate box to be updated/amended and indicate the correct data.
12. For MEMBER TYPE, check the appropriate box which best describes your current membership status.
13. For Direct Contributors, except employed, sea-based migrant workers and lifetime members, indicate the profession, monthly income and proof of income to be submitted.
14. For Self-earning individuals, Kasambahays and Family Drivers, indicate the actual monthly income in the space provided.
15. In declaring dependents, provide the full name of the living spouse, children below 21 years old, and parents who are 60 years old and above totally dependent to the member.
16. Dependents with disability shall be registered as principal members in accordance with Republic Act 11228 on mandatory PhilHealth coverage for all persons with disability (PWD).
17. The registrant must affix his/her signature over printed name (or right thumbmark if unable to write) and indicate the date when the PMRF was signed.