PUBLIC ASSISTANCE CENTER

MEDICAL ASSISTANCE FORM

DATE: ____________________

PATIENT'S INFORMATION: **must be a patient of the requested hospital*

____________________	____________________	____________________
FIRST NAME	***MIDDLE NAME***	***SURNAME***
____________________	____________________	____________________
DATE OF BIRTH	***AGE***	***CONTACT NUMBER***
	____________________	
	E-MAIL ADDRESS	

HOME ADDRESS: ____

HOSPITAL: ____

DIAGNOSIS: ____

ASSISTANCE NEEDED: ____

Hospital bill / Operation / Diagnostic Procedure / Dialysis / Medicines / Others

REPRESENTATIVE'S NAME: ____

RELATION TO THE PATIENT: ______________________ CONTACT NO.: ______________

Documentary requirements to be attached:

1. Personal letter to the Senator
2. Medical Certificate or Clinical Abstract
3. Quotation of medicines / hospital bills
4. Copy of Patient's ID and Representative's ID

*** Email to* ***pac@senate.gov.ph***