



PHILIPPINE MEDICAL ASSOCIATION

THEME: "PMA: WORKING TOGETHER AS ONE"

Member : World Medical Association
Co-Founder : Confederation of Medical Associations in Asia and Oceania (CMAAO)
Medical Association of South East Asian Nations (MASEAN)
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MEMORANDUM CIRCULAR NO: 2021 -11-03- 025

To : TO ALL CONCERNED PMA MEMBERS IN GOOD STANDING

Subject : SPECIAL ASSISTANCE FOR MEMBERS WHO CONTRACTED SEVERE TO CRITICAL COVID-19 INFECTION

This is to inform all concerned that the PMA Board of Governors on its 5th regular board meeting held last October 23, 2021 has approved the recommendation of the Commission on Mutual Aid to extend financial assistance to PMA members in good standing who contracted Severe to Critical COVID-19 infection subject to availability of funds;

Those members in good standing who contracted severe to critical pneumonia due to COVID-19 infection from June 1, 2021 may start filing for special assistance through their respective component societies and shall be granted assistance amounting to Php10, 000 as approved per Board Resolution #111, series of 2021.

The component society officers shall see to it that the special assistance applications are dutifully processed at reasonable time upon receipt of the complete documents and forwarded to the Commission on Mutual Aid thru email address philmedas@yahoo.com or mail to Commission on Mutual Aid, 2nd Floor Admin Building, Philippine Medical Association, North Avenue, Quezon City.

For those qualified, kindly submit the following requirements:

1. Duly Accomplished Application Letter
2. Medical Abstract of hospital confinement indicating severe to critical case of covid
3. Copy of Covid-19 positive RT-PCR result
4. Certificate of good standing
5. Disability Notification form endorsed by the Component Society

This resolution shall be without prejudice to the death, disability and legal aid benefits covered by the Mutual Aid Code which shall be continuously extended to its qualified members.

Death benefits can be claimed by the beneficiaries within two years from the time of death of the member in good standing together with the following requirements:

1. Duly Accomplished letter of application
2. Photocopy of Death Certificate
3. Name of beneficiary (Marriage Contract for Spouse)
4. Endorsement from the Component Society

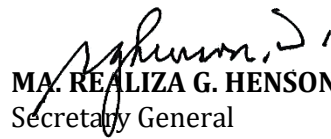
For clarification on benefit claims pls refer to the PMA Mutual Aid Code - (<https://www.philippinemedicalassociation.org/wp-content/uploads/2018/07/Physicians-Mutual-Aid-Code.pdf>)

For further details, you may also coordinate with Ms. Tracy G. Salcedo at mobile numbers 09608670258/09151321638 during office hours.


FOR YOUR GUIDANCE AND COMPLIANCE.



ENRICO E. IGNACIO SR., MD
Chairman, Commission on Mutual Aid



MA. REALIZA G. HENSON, MD
Secretary General



BENITO P. ATIENZA, MD
President



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: <input type="checkbox"/> Vision Impairment. <input type="checkbox"/> Deafness/hearing impairment <input type="checkbox"/> Mental health impairment <input type="checkbox"/> Acquired brain Injury <input type="checkbox"/> Physical disability <input type="checkbox"/> Others: Specify: <u> e.g. Cancer </u> _____	Nature of Treatment/ Treatment Required: <input type="checkbox"/> Medical Management <input type="checkbox"/> Surgery <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Immunotherapy <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Rehabilitation Services <input type="checkbox"/> 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:	