ANNEX A

REQUIREMENTS FOR THE
ACCREDITATION OF MEDICAL IT
SERVICE PROVIDER
REQUIREMENTS FOR THE ACCREDITATION OF MEDICAL IT SERVICE PROVIDER

I. ACCREDITATION

An Accreditation is an official document issued by the LTO that authorizes any person, natural or juridical, to provide IT services to medical clinics in accordance with the standards and procedures set forth by the LTO. It shall be valid for a period of one (1) year and renewable for the same period.

There shall only be four (4) Medical IT Service Providers to be issued of accreditation and on a first come first served basis, but may later be increased over time as deemed necessary by the LTO so as not to affect the delivery of public service.

II. QUALIFICATIONS

Any natural person who is at least 18 years of age or any juridical person with no derogatory record or who is not otherwise disqualified by any existing law or regulation including the applicant’s personnel, may apply for an authorization provided that the requirements herein are complied with; provided further, that no DOTr/LTO personnel, his/her spouse, or his relative by consanguinity or affinity within the third civil degree, shall have ownership of or any beneficial and/or financial interest therein.

Medical IT Service Providers or any of its personnel shall take no interest, directly or indirectly, over ownership, control, or management of any medical clinics engaged in the business of issuing medical certificate for LTO’s drivers license related transactions, nor shall they have any financial or material interest in any transaction relative to the operation of medical clinics which tends to conflict with their functions to the prejudice of the public interest.

III. DOCUMENTARY REQUIREMENTS

a. New Application

1. Letter of Intent;
2. Duly accomplished application form, under oath;
3. For sole proprietorship, DTI Certificate of Business Name Registration for sole proprietorship;
4. For corporation and partnership, Securities and Exchange Commission Certificate of Registration, Articles of Incorporation/Partnership and By-Laws and Secretary’s Certificate specifying the name of the authorized representative who must be an officer of the corporation/partnership;
5. For cooperative, Cooperative Development Authority Certificate of Registration, Articles of Cooperation and By-Laws, and Secretary’s Certificate specifying the name of the authorized representative who must be an officer of the cooperative;
6. Certified True Copy of Mayor’s or Business Permit;
7. BIR Registration and Tax Identification Number;
8. SSS Membership Certificate;
9. Audited pre-operating Financial Statements showing the financial capacity of the applicant to operate for at least two (2) years;
10. Location map and layout of the office, including dimensions;
11. Organizational structure showing the relationship between the provider and other operations of the firm, when applicable, and the structure of the office showing its personnel and their functions
   • List of personnel with their job descriptions, responsibilities and qualifications
   • List of equipment, including manuals and reference materials
Source Code and complete description of executable files. Source code shall be open for Assessment Team evaluation and shall only be compiled in the presence of Assessment Team or any of its authorized representatives.

12. Bank Certificate of Deposit in the amount of not less than P5,000,000.00;
13. Payment of Application Fee of ten thousand pesos (P10,000) which is non-refundable
14. Such other documents or requirements that the DOTr/LTO may require from time to time to protect the interest of the government and the public.

b. Renewal of Authorization

1. Duly accomplished application form, under oath
2. Original LTO Certificate of Authorization
3. Certified true copy of Mayor’s Permit
4. Income Tax Return for the current year, duly stamped and received by the BIR
5. Duly Sworn Affidavit attesting to its continuing compliance with all the requirements for authorization, unless there are changes thereto, in which case the applicant shall submit the applicable documents
6. List of Medical Clinics/Clients
7. Payment of Renewal Fee of five thousand pesos (P5,000) which is non-refundable
8. Such other documents or requirements that the DOTr/LTO may require from time to time to protect the interest of the government and the public.

IV. FILING

The documentary requirements for the application must be filed at the LTO Central Office-Maintenance Information Division which shall review and evaluate its completeness and authenticity and shall approve the application.

IV. PERSONNEL

The Medical IT Service Provider shall consist of the following personnel:

a. IT Service Manager
   Manage overall operations of the company; ensure proper, reliable and high level standards of IT services provided to medical clinics;

b. Technical Personnel
   Must be a graduate of any IT-related course with appropriate trainings and backgrounds on network and database management. He shall maintain the network and database

c. Programmer
   Must have education, trainings and background in software development with at least a year of experience as programmer in a company. He must be a full stack developer (must be able to work on both the front-end and back-end portions of an application)

d. Administrative Assistant
   Provide office or administrative support/functions in the company

V. OPERATIONAL, SOFTWARE AND HARDWARE REQUIREMENTS
a. All Medical IT Service Provider shall provide the medical clinics a Medical Application Program that shall adhere to the following specs:

1. The Application Program must be a web based application for data transmission and authentication.
2. The application program shall automatically synchronize the date and time of the workstation to the Medical IT Service Provider servers and the LTO IT System.
3. The Application Program shall automatically detect the biometric systems and computer-based medical equipment. The program shall prompt the user if a device is disconnected.
4. No medical result transmission shall be delayed. The medical result shall be transmitted to the IT Provider and LTO's servers real-time.
5. The Application Program shall require a fingerprint verification to be able to log into the application program. For uniformity and to ensure compatibility to the new LTO-IT System, the current LTO fingerprint scanner (Dermalog) shall be used by all medical clinics.
6. Fingerprint verification of the examining registered physician shall be required by the application program for each medical result to authorize the upload.
7. The Application Program shall be integrated with computer based acuity, contrast sensitivity and auditory test equipped with a digital camera & signature pad to capture the photograph & signature of the driver/conductor applicant.
8. The Application Program shall not accept medical results generated by other software.
9. Only the physicians who are qualified and enrolled in the system shall be able to access and transmit medical result.
10. The application program shall be ready to be integrated to the incoming new LTO IT System.
11. The application program shall automatically generate the results based on the outcome of the examination and shall conform to the prescribed medical result format.
12. The application program shall not allow any form of modification on the results of the medical equipment interfaced with the workstation.
13. The application program shall not allow re-examination of failed applicants for one (1) day and until sufficient documents or clearance from the medical specialist are shown that proves the impairment of the applicant was corrected.
14. The application program shall not start the examination unless all medical equipment necessary are connected to the workstation.
15. The application program shall follow the prescribed medical result format in data transmission. Transmission and printing of medical certification/result shall not be possible unless all data required are present as well as the duration (8mins) of all medical examination procedures has been consumed.
16. All medical result transmitted shall have a unique identification number generated automatically by the application program.
17. The application program shall keep medical records for ten (10) years until the record can be deleted.
18. The Application Program shall include a timer to show how much time is left before proceeding to the next step of the medical examination. The applicant cannot proceed to the next step until the allotted time for the corresponding step is consumed.

b. All source code which must be submitted to the LTO Management Information Division for evaluation and approval; and shall only be compiled in the presence of any LTO-MID authorized representatives.

c. System set-up and network layout.

d. The Medical IT Service Provider must have a main database server that shall accept incoming medical result transmissions from the clinics and shall have another separate...
active database server acting as backup. The main database server and the backup
database server shall be both active but shall not be contained in the same building.
The Database Server must be capable to store 10 years worth of medical
results/certifications and shall be installed with the latest software and drivers.

e. The Medical IT Service Provider must have its own Domain Name and shall be the one
to host the medical application program.

f. The Medical IT Service Provider shall provide a Virtual Private Network to the Medical
Clinic to secure medical result transmission.

g. Medical IT Service Provider is required to report incident or any technical breach within
twenty-four (24) hours from the time of its occurrence including but not limited to failure
to upload medical test results;

h. No re-print request shall be authorized if the present date is later than fifteen days from
the date and time the DL applicant is checked-up by the registered LTO physician;

i. No demo transaction shall be uploaded to the LTO IT System;

**It is noted however that the medical clinics may be able to directly upload the medical
examination results/certificates, without intercession of the IT Providers, in the New LTO IT
System through the LTO Portal once the development of the application software has been
completed.**
ANNEX B
DRIVER'S MEDICAL EVALUATION FORM
INSTRUCTION: Complete and sign before submitting to the examining physician. PLEASE WRITE LEGIBLY.

SECTION 1 - ADVISORY STATEMENT
Medical information provides the examining physician an overview of your general health and enable him/her to focus on certain aspects which may require further examination and/or testing. The data on your physical and mental fitness is required to determine your driving qualifications. Failure to provide the information required herein is cause for refusal to issue a license or to withdraw driving privilege.

You are required by law to disclose any and all conditions that could affect the safe operation of a motor vehicle. Willful misrepresentation with respect to material information in driver's/conductor's license application including health condition/s is punishable by a fine of P20,000.00 (Section 23-B of R.A. 4136, as amended by R.A. 10930).

SECTION 2 – APPLICANT INFORMATION

<table>
<thead>
<tr>
<th>NAME (LAST, FIRST, MIDDLE)</th>
<th>BIRTHDATE (mm/dd/yyyy)</th>
<th>AGE</th>
<th>SEX</th>
</tr>
</thead>
</table>

COMPLETE ADDRESS
NATIONALITY
CIVIL STATUS
OCCUPATION

<table>
<thead>
<tr>
<th>Student-Driver's Permit</th>
<th>Nonprofessional</th>
<th>New</th>
<th>Renewal</th>
<th>LICENSE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conductor's License DL</td>
<td>Professional DL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Miscellaneous</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION 3 – COMPLETE HEALTH HISTORY

HAVE YOU BEEN DIAGNOSED, TREATED OR CONFINED FOR THE FOLLOWING? (Explain any "YES" answers in space below)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, neck, spinal injury, disorders or illnesses</td>
<td>Kidney disease, stones, blood in urine or dialysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizure, convulsions, or epilepsy</td>
<td>Muscular disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness, fainting, or frequent headaches</td>
<td>Sleep disorders including sleep apnea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye problem (except corrective lenses)</td>
<td>Nervous or psychiatric disorder including PTSD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing or ear problems</td>
<td>Anger management issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension or other cardiovascular disease</td>
<td>Regular or frequent alcohol/drug use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart attack, stroke, or paralysis</td>
<td>Involved in a motor vehicle accident while driving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung disease (include tuberculosis or asthma)</td>
<td>Any major illness, injury or operation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperacidity, ulcer, or digestive problems</td>
<td>Any permanent impairment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes or high blood sugar</td>
<td>Other disorders or diseases</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EXPLANATION FOR YES ANSWERS: (Include onset date, diagnosis, medication, and any current condition or limitation)

SECTION 4 – PRESENT CONDITION/S AND TREATMENT

ARE YOU PRESENTLY EXPERIENCING ANY ADVERSE SYMPTOM/S THAT NEED MEDICAL ATTENTION? If Yes, explain.

☐ Yes ☐ No

HOW OFTEN DO YOU SEE A PHYSICIAN?

DATE OF LAST EXAMINATION BY A PHYSICIAN:

HAVE YOU BEEN HOSPITALIZED WITHIN THE LAST FIVE (5) YEARS?

☐ Yes ☐ No

If Yes, state reason:

DATE OF LAST CONFINEMENT (If applicable):

SIGNATURE OF APPLICANT

DATE: DEC 4, 2018
LIST THE MEDICATIONS PRESCRIBED OR USED REGULARLY OR RECENTLY. (Please include dosage and frequency of use)

IMPORTANT

I certify to the best of my knowledge under penalty of perjury that the information I have provided in the preceding sections of this form is true and correct. I understand that any inaccurate, false, or missing information may invalidate the medical examination and the corresponding medical certificate.

DATE

APPLICANT'S SIGNATURE OVER PRINTED NAME

SECTION 5 – MEDICAL INFORMATION AUTHORIZATION

ACCREDITED MEDICAL CLINIC (NAME AND ADDRESS)

I hereby give my consent, as data subject, to the collection and processing of my personal information, including my sensitive personal information, privileged information, and that information pertaining to my health as a result of the medical examination to be performed, by the above-named medical clinic and its examining physician. I further authorize said medical clinic to transmit to the Land Transportation Office the information required in my application for license.

I hereby authorize the Land Transportation Office to receive information relating to my physical and mental condition, and/or drug and/or alcohol use or abuse, and to use the same in determining my fitness to operate a motor vehicle safely.

DATE

APPLICANT'S SIGNATURE OVER PRINTED NAME

STOP! DO NOT WRITE BEYOND THIS PORTION.

Fields below to be filled up by authorized medical clinic personnel/examining physician only.

SECTION 6 – INITIAL ASSESSMENT

HEIGHT (CENTIMETERS): WEIGHT (KILOGRAMS): BODY MASS INDEX (BMI) EYE COLOR: BLOOD TYPE:

Information provided by applicant

BLOOD PRESSURE (mmHg): BODY TEMPERATURE: PULSE RATE: RESPIRATORY RATE:

REMARKS (Include observations that may affect safe driving):

Initial Assessment performed by:

Name and Signature of Medical Clinic Personnel

SECTION 7 – EXAMINING PHYSICIAN’S INFORMATION AND SIGNATURE

I have reviewed the foregoing medical information of the applicant which shall be the basis for an in-depth medical examination and in the issuance of the corresponding medical certificate.

SIGNATURE OF REGISTERED EXAMINING PHYSICIAN

NAME OF EXAMINING PHYSICIAN

DEC 16 2018
<table>
<thead>
<tr>
<th>DATE OF EXAMINATION</th>
<th>PRC LICENSE NO.</th>
</tr>
</thead>
</table>

**SERIAL/REFERENCE NO. OF MEDICAL CERTIFICATE ISSUED:**

**NOTE: THIS DOCUMENT MUST BE KEPT ON FILE BY THE MEDICAL CLINIC FOR AT LEAST TEN (10) YEARS.**
ANNEX C
MEDICAL CERTIFICATE FORM
### MEDICAL CERTIFICATE FOR DRIVERS LICENSE

#### APPLICANT'S INFORMATION
- **NAME:**
- **SURNAME**
- **FIRST NAME**
- **MIDDLE NAME**
- **ADDRESS:**
- **DRIVER LICENSE NUMBER:**
- **DATE OF BIRTH:**
- **NATIONALITY:**
- **AGE:**
- **GENDER:**
- **MARITAL STATUS:**

#### PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>GENERAL PHYSIQUE</th>
<th>CONTAGIOUS DISEASE</th>
<th>BLOOD PRESSURE</th>
<th>BLOOD TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>With Disability</td>
<td>With Disease, pls specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HEIGHT:** ___ (cms) **WEIGHT:** ___ (kgs)

<table>
<thead>
<tr>
<th>UPPER EXTREMITIES:</th>
<th>LOWER EXTREMITIES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEFT</td>
<td>RIGHT</td>
</tr>
<tr>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>With disability</td>
<td>With disability</td>
</tr>
<tr>
<td>With special equip</td>
<td>With special equip</td>
</tr>
</tbody>
</table>

#### VISUAL TEST

**Visual Acuity:**
- **LEFT EYE:** SNELEN/BAILEY-LOVIE
  - Normal
  - With corrective lens
  - Color blind
- **RIGHT EYE:** SNELEN/BAILEY-LOVIE
  - Normal
  - With corrective lens
  - Color blind

#### AUDITORY TEST

- **LEFT EAR:**
  - Normal
  - Reduced
  - With hearing aid
- **RIGHT EAR:**
  - Normal
  - Reduced
  - With hearing aid

#### METABOLIC AND NEUROLOGICAL DISORDERS

- **DIABETES**
  - Is it under proper control or medication? Yes No
- **EPILEPSY**
  - Date of last seizure
- **SLEEP APNEA**
  - Is it under medication? Yes No
- **AGGRESSIVE, MANIC OR DEPRESSIVE ORDER**
  - Is it under proper treatment or medication? Yes No
- **OTHER MEDICAL CONDITION OR IMPAIRMENT WHICH MAY AFFECT ABILITY TO DRIVE SAFELY**
  - Is it under proper treatment or medication? Yes No

#### ASSESSMENT

- Fit to drive
- Unfit to drive
  - Permanent
  - Temporary
  - Refer to Specialist for further Evaluation

#### CONDITIONS

- None
- Drive only with corrective lens
- Drive only with special equipment for Upper limbs
- Drive only with special equipment for Lower limbs
- Drive only during daylight
- Drive only with hearing aid

#### PHYSICIAN
- **PRC LICENSE NUMBER**
- **PTR NUMBER**
- **ISSUED AT**
- **CERTIFICATE #**
- **SIGNATURE**

#### REMARKS:

- **DATE ISSUED:**
- **THIS MEDICAL CERTIFICATE IS VALID UNTIL**
- (60 DAYS FROM DATE OF ISSUE)
ANNEX D
APPLICATION FOR ACCREDITATION OF MEDICAL CLINIC
### Application for Accreditation of Medical Clinic

**Name of Clinic**

**Address of Clinic**

No. & Street Barangay City/Municipality Province Zip Code

**Contact Number**

**Fax No.**

**E-mail Address**

**Owner of Clinic**

**Type of Organization (Please Check)**

- [ ] Sole Proprietorship
- [ ] Partnership
- [ ] Cooperative

**Classification:**

- [ ] Private
- [ ] Government

**Type of Health Facility or Services:**

- [ ] Medical Clinic
- [ ] Others (Specify)

**Status of Application:**

- [ ] Initial
- [ ] Renewal

LTO Service Area

**Documentary Requirements: (Please present the originals)**

<table>
<thead>
<tr>
<th>PRIVATE CLINIC</th>
<th>GOVERNMENT CLINIC OR HEALTH FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Duly accomplished application form under oath signed by the owner;</td>
<td>1. Duly accomplished application form under oath signed by the Head of Agency;</td>
</tr>
<tr>
<td>2. Certified true copy of the following:</td>
<td>2. Health Facility geographic form [location map] (Annex D) and layout of the clinic, including dimensions;</td>
</tr>
<tr>
<td>a. For sole proprietorship, Certificate of Business Name Registration;</td>
<td>3. Photographs of the exterior and interior of the medical clinic;</td>
</tr>
<tr>
<td>b. For corporation/partnership, Securities and Exchange Commission Certificate of Registration and Articles of Incorporation/Partnership and Board Resolution issued by the Board Secretary, specifying the name of authorized representatives who must be an officer of the corporation/partnership;</td>
<td>4. Chart of organizational structure showing its personnel and their positions;</td>
</tr>
<tr>
<td>c. For cooperative, Cooperative Development Authority Certificate of Registration and Articles of Cooperation and Board Resolution, issued by the Board Secretary, specifying the name of authorized representative who must be an officer of the cooperative;</td>
<td>5. List of personnel involved with the operation including their job descriptions, responsibilities and qualifications, including the certified true copy of their approved appointments or certificates of employment;</td>
</tr>
<tr>
<td>3. Mayor's Permit or Permit to operate business issued by the proper local government unit;</td>
<td>6. List of all equipment, including manuals, reference materials required for its calibration;</td>
</tr>
<tr>
<td>4. Bureau of Internal Revenue Registration and Taxpayer's Identification Number;</td>
<td>7. Such other documents that the LTO may require from time to time to protect the interest of the government and the public.</td>
</tr>
<tr>
<td>5. Audited Financial Statement for the last two (2) years or a Pre-operating Financial Statement whichever is applicable, showing that the owner-applicant shall be in such financial condition as to reasonably expect it to operate for at least one (1) year;</td>
<td></td>
</tr>
<tr>
<td>6. Health Facility geographic form [location map] (Annex D) and layout of the clinic, including dimensions;</td>
<td></td>
</tr>
<tr>
<td>7. Certificate of Registration of personal information processing system as proof of registration with the National Privacy Commission in accordance with Republic Act No. 10173 or the Data Privacy Act;</td>
<td></td>
</tr>
<tr>
<td>8. Photographs of the exterior and interior of the medical clinic;</td>
<td></td>
</tr>
<tr>
<td>9. Chart of organizational structure showing the relationship between the clinic and other operations of the firm, when applicable, and of the clinic showing its personnel and its functions;</td>
<td></td>
</tr>
<tr>
<td>10. List of personnel involved with the operation of the clinic including their job descriptions, responsibilities and qualifications, including the Certificate of Registration duly issued by the Board of Medical Examiners to physician and nurses employed therein;</td>
<td></td>
</tr>
<tr>
<td>11. List of all equipment, computer based examination including manuals, reference materials required for its calibration;</td>
<td></td>
</tr>
<tr>
<td>12. Such other documents that the LTO may require from time to time to protect the interest of the government and the public.</td>
<td></td>
</tr>
</tbody>
</table>

I declare under oath that I have personally accomplished the Application for Registration of Physician which is a true, correct and complete statement pursuant to the provisions of pertinent laws, rules and regulations of the Republic of the Philippines. I authorize the registering agency head/authorized representative to verify validate the contents stated herein. I agree that any misrepresentation made in the document and its attachments shall cause the filing of administrative/criminal cases against me.

---

Printed Name and Signature of Applicant

Designation

Data of Application

Subscribed and sworn to me before this day of , 20__

Affiant exhibiting to me Higher Residency Certificate

Doc. No.

Page No.

Book No.

Series of

To be filled out by LTO

Evaluated by:

Date:

Approved by:

Date:

LTO Accreditation Number:

LTO Authorized Personnel (Printed Name & Signature)

LTO Authorized Signatory (Printed Name & Signature)

Validity:
ANNEX E
HEALTH FACILITY GEOGRAPHIC FORM
**REPUBLIC OF THE PHILIPPINES**  
**LAND TRANSPORTATION OFFICE**  

**HEALTH FACILITY GEOGRAPHIC FORM**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Name of the Medical Clinic/Facility:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2. Region:</strong></td>
<td>(example: Region 1 - Ilocos Region)</td>
</tr>
<tr>
<td><strong>3. Street name and number:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>4. Building name and number:</strong></td>
<td>(Write N/A if none)</td>
</tr>
<tr>
<td><strong>5. Province:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>6. City/Municipality:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>7. Barangay:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>8. Nearest LTO Office:</strong></td>
<td>(example: San Fernando District Office)</td>
</tr>
<tr>
<td><strong>9. Contact Number:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>10. Can it be located using Google Map?</strong></td>
<td>(Yes or No)</td>
</tr>
<tr>
<td><strong>11. Zoom Scale:</strong></td>
<td>(Max of 20m)</td>
</tr>
<tr>
<td><strong>12. Latitude:</strong></td>
<td>(example: 16.609468)</td>
</tr>
<tr>
<td><strong>13. Longitude:</strong></td>
<td>(example: 120.318509)</td>
</tr>
</tbody>
</table>

*Attach two copies of screenshot of the Medical Clinic/Facility using Google Map Satellite.*

*Attach your Floor Plan/Clinic Layout.*

**Steps on how to get the Latitude and Longitude:**

2. Input your address/location in the **SEARCH GOOGLE MAPS BAR.**
3. After searching your address/location, click on the “Satellite” to change view.

4. Right Click on your Medical Clinic/Facility and select “What’s Here?” to show the Latitude and Longitude (Latitude is followed by Longitude). Zoom scale can be found at the bottom right of Google Maps (Click on the scale meter to change unit of measurement).
# Republic of the Philippines

## Department of Transportation

**LAND TRANSPORTATION OFFICE**

**APPLICATION FOR REGISTRATION OF PHYSICIAN**

### CLINICAL INFORMATION

- **Clinic Name:**
- **Address:**
- **Medical Clinic Accreditation Number:**

### PHYSICIAN INFORMATION

- **Last Name:**
- **First Name:**
- **Middle Name:**
- **Birth Date:**
  - Month
  - Day
  - Year

### Documents Submitted by Applicant:

- Two pieces 2x2 photo with name tag within the last three months from the date of application for registration;
- Certified true copy of Certificate of Registration duly issued by the Board of Medical Examiners;
- Certificate of Membership and good standing from the Medical Association of its component society;
- Photocopy of the valid Professional Regulation Commission license card (original copy presented during registration);
- Copy of valid government issued identification card (other than PRC) with photo and signature (original copy presented during registration);
- Current Professional Tax Receipt (PTR) number except for government physician;
- Taxpayer’s Identification Number (TIN);
- Digital Photograph and Biometric Scan of the Physician;
- For government physicians, certified true copy of approved appointment or Certificate of Employment issued by the agency;
- For government physicians who desire to engage in private practice, Authority to Engage in the Private Practice of Profession approved by the Head of Agency where he/she is employed.

### Approved by:

- **Date:**
- **LTO Authorized Signatory**
  - (Printed Name & Signature)

### Fingerprint Impression of Registered Physician

*Note: Must be taken by authorized LTO personnel immediately after registration*

- **Right Thumb**
- **Right Index Finger**
- **Left Middle Finger**
- **Right Ring Finger**
- **Right Little Finger**
- **Left Little Finger**
- **Left Ring Finger**
- **Left Middle Finger**
- **Left Index Finger**
- **Left Thumb**