# ANNEX “A”

**AFFIDAVIT-DECLARATION THAT NO PROFESSIONAL FEE**

**HAS BEEN CHARGED BY MEDICAL PRACTITIONER**

 We, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, of legal age, single/ married

 *(Name of Patient/Authorized Representative) (Citizenship)*

permanently residing at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, of legal age, single/ married

 *(Medical Practitioner) (Citizenship)*

permanently residing at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ with

Taxpayer Identification Number (TIN) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, after having been duly sworn in accordance with law

hereby depose and state:

1. That \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is a patient in the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(Name of Patient)* *(Name of Hospital/Clinic)*

having been confined from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ due to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_;

1. That \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is the authorized representative/guardian of the herein-mentioned patient;

1. That \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is the attending physician of the herein-mentioned patient for the duration of the stay in the herein-mentioned hospital;
2. That no professional fee was charged by the aforesaid physician, the patient being his/her \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_;
3. That we duly execute this **SWORN DECLARATION** in compliance with the requirement prescribed under Section \_\_\_\_ of Revenue Regulations No. \_\_\_\_\_\_\_\_;
4. That I declare, under the penalties of perjury, that this declaration has been made in good faith, and to the best of my knowledge and belief to be true and correct.

**IN WITNESS WHEREOF,** we have hereunto set my hand this \_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_, Philippines

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Signature over Printed Name of Patient/Guardian Signature over Printed Name of Medical Practitioner*

*Govt. ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Govt. ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Issued at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Issued at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Issued on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Issued on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 **SUBSCRIBED AND SWORN** to before me this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_ in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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