

Republika ng Pilipinas
Kagawaran ng Edukasyon
REHIYON V (BIKOL)

TANGGAPANG PANSANGAY NG MGA PAARALAN NG CATANDUANES


20 February 2026

DIVISION MEMORANDUM
NO. 272 s. 2026

**CORRIGENDUM TO DIVISION MEMORANDUM NO. 234 S. 2026 RE: GRANT OF
MEDICAL ALLOWANCE FOR FISCAL YEAR 2026**

TO: Assistant Schools Division Superintendent
CID and SGOD Chiefs & Personnel
OSDS Unit Heads & Personnel
Elementary and Secondary School Heads
All Teaching and Non-Teaching Personnel
All Others Concerned

1. Relative to the Division Memorandum No. 234 s. 2026, "Grant of Medical Allowance for Fiscal Year 2026", enclosed is the correct Medical Allowance Registration Form (ANNEX A).
2. Schools which have already submitted their Medical Allowance Registration Form are advised not to submit again.
3. All other provisions stated in the previously issued memorandum shall remain in effect.
4. For information, guidance and strict compliance.


MA. JEANY T. ABAYON
Assistant Schools Division Superintendent
OIC, Schools Division Superintendent



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Enclosure 1 to the DM 272 s. 2026

Annex A

Medical Allowance Registration Form

Data Privacy Notice: The Department of Education recognizes its responsibility under the Republic Act No. 10173, otherwise known as the *Data Privacy Act of 2012*, with respect to the data they collect, record, organize, update, use, consolidate, or destruct from their personnel. The personal data obtained from this form is entered and stored within the organization's authorized information and communications system and will only be accessed by authorized personnel. The organization has instituted appropriate technical and physical security measures to ensure the protection of personal data.

Furthermore, the information collected and stored in the portal shall only be used for the purposes of this activity. DepEd shall not disclose any personal information without consent and shall retain this information over a period of ten years for the effective implementation and management of its activities.

Section 1: Employee Information

Full name: _____
 Employee ID Number: _____
 Position/Designation: _____
 Office: _____
 Date Appointment(dd/mm/yyyy): _____
 Sex: _____ Date of Birth (dd/mm/yyyy): _____
 Mobile Number: _____ DepEd Email Address: _____

For teaching personnel:

Region: _____
 Division: _____
 School: _____
 Employment Status: Permanent Contractual
 Casual Substitute

Section 2: Form of Availment

Kindly select one:

- Group
- Agency Procurement
- Individual
- Payroll Disbursement for availment of new/renewal of own HMO)
- Cash form for payment of medical expenses

Section 3: Certification

I, hereby confirm that the information provided above is accurate and truthful. I agree to comply with the terms and conditions outlined in the Guidelines on the Grant of Medical Allowance to DepEd personnel, including the submission of required documents for verification and processing.

Employee's Signature: _____ **Date:** _____



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