UNIVERSITY OF CEBU MEDICAL CENTER

Ouano Ave., North Reclamation Area, Mandaue City
Tel No. (032) 517.0888

APPLICATION FORM FOR MEDICAL STAFF

Department: _____ ☐ *Active Staff* ☐ *Visiting Consultant*

Name: (Family)	*(First)*	*(Middle)*	*PRC NUMBER :*
Mailing Address:			*Mobile Number:*
Clinic Address:			*Telephone Number:*
Residence:			*Telephone Number:*
Nationality:	*Date of Birth:*	*Age:*	*Status:*
E-mail Address:			*Fax Number:*

Educational Attachments (Please provide separate sheets if necessary)

Name of Institution	*Location*	*Dates*	*Degree*

Postgraduate Training and / or Courses: (Please provide separate sheets if necessary)

Name of Institution	*Location*	*Dates*	*Degree*

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Postgraduate Training and / or Courses: (Please provide separate sheets if necessary)

Name of Institution	*Location*	*Dates*	*Degree*

Fellowship and / or Board Certification of Specialties in:

Scientific Papers and / or Publications:

Membership in Medical Organization:

Date: _____

_____
Signature of Applicant

Recommendation:

_____
Department Head

_____
Chairman Credentials Committee

Revision: 0003 -9.14

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List of Dependents:

Name: (Family)	*(First)*	*(Middle)*	*Birthdate*	*Relationship*

Requirements for Medical Staff:

Remarks:

1. Application Letter addressed to the Medical Director _____
2. Curriculum Vitae _____
3. Medical School Diploma _____
4. PRC ID _____
5. Certificate of Specialty Training from an approved Residency Program _____
6. Specialty Board Certificate _____
7. Certificate of Subspecialty Training (Fellowship) _____
8. Fellowship certificates in specialty & sub-specialty societies (where applicable) _____
9. CMS, PMA Number _____
10. TIN, ACLS/BLS, PTR, S2 (optional) _____
11. Phil Health Accreditation _____
12. 2x2 photos (2pcs) and 1 Whole Body Picture with Smock Gown _____
13. Letters of Recommendation from two Active Staff members of the Department where trained. _____

All applications will be subject to final approval by the Board.