APPLICATION FOR RESIDENCY TRAINING PROGRAM

2 x 2
Recent Photo

Department of _____

Name of Applicant: _____ _____ _____
Last Name First Name Middle Name

Date of Birth: _____ Birthplace: _____
Citizenship: _____ Religion: _____
Gender: ☐ M ☐ F Marital Status: _____ Number of dependents: _____
Present address: _____ Zip code _____
Permanent address: _____ Zip code _____
Contact numbers: (Cell phone no.) _____ Landline no.: _____
Email Address: _____
Personal Identification:
TIN: _____ PRC #: _____ Valid until: _____
PhilHealth Membership # _____ S2 #: _____ Valid until: _____
Other gov't issued ID's _____ _____ Valid until: _____
(For Foreigners) Passport Number: _____ Valid until: _____
Issued place/date: _____
Name of spouse: (Last name, First name, Middle name) _____
Mailing address: _____
Whom to notify in case of emergency: _____
Mailing Address: _____
Relationship: _____ Contact number: _____

MEDICAL EDUCATION:

College or University: _____ Date of Graduation: _____
Honors or Awards: _____
Date when Medical Board Exam was taken: _____ Rating: _____
Other examinations taken and results (ie. USMLE, BQE, etc.) _____
Postgraduate Internship: _____ Inclusive Date: _____
Other trainings: _____ Inclusive Date: _____

Character References: (Include hospital affiliation, position, contact numbers)

1. _____
2. _____
3. _____

Do you have an ongoing or previous litigation case/ court case/ administrative case? ☐ Yes ☐ No
If yes, please provide details _____

I hereby attest to the accuracy of the information given above. Any form of dishonesty will be considered grounds for my expulsion from the institution.

_____
Applicant's Full Name & Signature
Date _____

(This part to be filled up by the Department):

Evaluation: ☐ exceptionally good ☐ satisfactory ☐ good/average ☐ poor

Recommendation: ☐ accept ☐ do not accept

Evaluators: **(Training Officer 1)** _____

(Training Officer 2) _____

Noted by: (DEPARTMENT CHAIR) _____

REQUIREMENTS: Please attach the following documents (Photocopy and original for verification)

- ☐ Completely filled-up application form (*download at CGHMC website*)
- ☐ Curriculum Vitae
- ☐ 1pc. - 2x2 picture (colored)
- ☐ Letter of Intent
- ☐ (2) Two Recommendation Letters/ Character Reference
  Except for Graduates of CGHMC Training Program
- ☐ Complete Transcript of Medical Records (Certified True Copy)
- ☐ Class Ranking
- ☐ Medical School Diploma (Certified True Copy)
- ☐ Certificate of Internship (Certified True Copy)
- ☐ Medical Board Rating Result
- ☐ Valid PRC License/ PRC ID
- ☐ Valid PTR
- ☐ TIN ID/BIR Form 2303
- ☐ PhilHealth Membership ID Number / MDR
- ☐ Valid ACLS/BLS certificate
- ☐ CXR (PA, lateral view) result done within 3 months of application
- ☐ HBsAg and anti-HBs titer done within 6 months of application
- ☐ Mental Health Certification (valid within 3 months before application) from a clinical psychologist or a licensed psychiatrist (especially if on medication)
- ☐ Immunization Record (If Available)
- ☐ Complete COVID-19 Vaccination Record

**Incomplete papers will not be processed.*
**Pls. bring all original documents for verification purposes.*
**All documents submitted shall remain the property of CGHMC-DMER and shall not be returned to applicant at any time for any reason.*