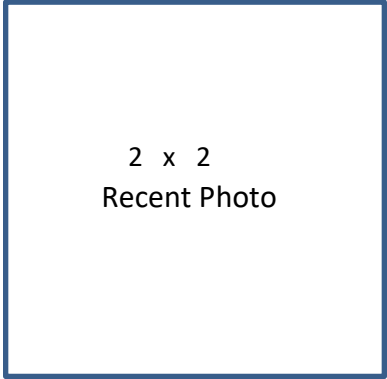




APPLICATION FOR RESIDENCY TRAINING PROGRAM



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)
- 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.*