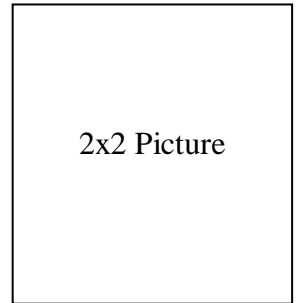




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DEPARTMENT	
<input type="checkbox"/> ANESTHESIA <input type="checkbox"/> DERMATOLOGY <input type="checkbox"/> ENT <input type="checkbox"/> INTERNAL MEDICINE <input type="checkbox"/> OB-GYNE <input type="checkbox"/> OPHTHALMOLOGY	<input type="checkbox"/> PATHOLOGY <input type="checkbox"/> PEDIATRICS <input type="checkbox"/> REHABILITATION MEDICINE <input type="checkbox"/> SURGERY OTHERS _____



**PERSONAL INFORMATION:**

LAST NAME:		FIRST NAME:		MIDDLE NAME:	
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE	DATE OF BIRTH:		PLACE OF BIRTH:	
CIVIL STATUS:	RELIGION	PRC #  EXPIRE (MM / YYYY)	PMA #  EXPIRE (MM / YYYY)		
ADDRESS:					
TELEPHONE NO.:		MOBILE NO.:		E-mail ADDRESS:	
SPOUSE NAME:		OCCUPATION:		CONTACT NO.:	
NAME OF CHILDREN /AGE	1. _____ 2. _____ 3. _____				

**EDUCATIONAL BACKGROUND:**

MEDICINE:	YEAR	
COLLEGE:	YEAR	
SECONDARY:	YEAR	
PRIMARY:	YEAR	
ACADEMIC AWARDS / CITATIONS:		


**INTERNSHIP:** (Please specify name of institution)

YEAR	INSTITUTION	AWARDS / RECOGNITIONS

**OTHER POST GRADUATE EDUCATION(S) ATTAINED:**

YEAR	INSTITUTION	AWARDS / RECOGNITIONS



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*WORK EXPERIENCE: (Attached additional sheet if needed)*

POSITION	INSTITUTION / COMPANY	YEAR

*PUBLISHED AND UNPUBLISHED WORKS (Use additional sheet if needed or attached supporting papers)*

TITLE	YEAR	UNPUBLISHED	PUBLISHED


*MEMBERSHIP TO ORGANIZATIONS / SOCIETY:*

ORGANIZATION / GROUP

*REFERENCE:*

NAME	COMPANY AND ADDRESS	CONTACT NO.



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*This portion is for the review and approval committee*

**ACTION TAKEN:**

DEPARTMENT:		
RECOMMENDATION:	<input type="checkbox"/> APPROVED	<input type="checkbox"/> DISAPPROVED
REMARKS:		
_____ DATE: _____ TRAINING OFFICER	_____ DATE: _____ DEPARTMENT CHAIRMAN	

CLINICAL SERVICES AND PATIENT CARE OFFICE		
RECOMMENDATION:	<input type="checkbox"/> APPROVED	<input type="checkbox"/> DISAPPROVED
REMARKS:		

\_\_\_\_\_  
 ASSISTANT MEDICAL DIRECTOR FOR CLINICAL SERVICES AND  
 PATIENT CARE  
 DATE: \_\_\_\_\_

OFFICE OF THE MEDICAL DIRECTOR		
RECOMMENDATION:	<input type="checkbox"/> APPROVED	<input type="checkbox"/> DISAPPROVED
REMARKS:		

\_\_\_\_\_  
 MEDICAL DIRECTOR  
 DATE: \_\_\_\_\_

OFFICE OF THE PRESIDENT		
DECISION:	<input type="checkbox"/> APPROVED	<input type="checkbox"/> DISAPPROVED

**ARLYN GRACE V. GUICO, MHA, Ed. D**  
 PRESIDENT / CEO  
 DATE: \_\_\_\_\_