FORTMED MEDICAL CLINICS

asb2014

MEDICAL STAFF APPLICATION

Complete Name: _____
(Surname) (First Name) (Middle Name)

KINDLY FILL OUT COMPLETELY WHERE APPLICABLE. FOR SPECIALIST BOLD ITEMS A MUST

I. Personal Data:

Home Address: _____ Tel. No.:_____
_____ Email: _____
Office Address: _____ Tel. No.:_____
_____ Cell No.:_____
Date of Birth:_____ Age:_____ Place of Birth:_____
Civil Status:_____ Religion:_____
T.I.N:_____ PTR #/Date of Issue:_____ PRC No.: _____Exp_____
PMA No.:_____ **PHIC Accreditation No.:**_____ **Expiry** _____
Name of Spouse:_____ Profession:_____
Name and Age of Children:_____
_____

II. Education:

	University/School	Degree	Inclusive Dates		Date Graduated
Pre-Medical					
Medical					
Other Degrees					

III. Post Graduate Medical Training:

	Institution	Address	Inclusive Dates
Internship			
Residency			
Fellowship			
Others			

IV. Eligibility/Certification:

Board Eligibility (Indicate license number and expiry date):

_____
_____

Board Certifications:

_____
_____

V. Current Positions:

Position	Institution	Address/Tel. No.

VI. Current Hospital Affiliation:

Hospital Name	Address/Tel. No.	Inclusive Dates	Status (active or visiting)

VII. **Current Academic Affiliation:**

School/University	Status	Inclusive Dates

VII. **Medical Society Membership:**

Name	Position	Date of Membership

VIII. **Professional/Character References:**

Name	Position	Institution (name, address & tel. no)

IX. **AVAILABILITY (days and time):**

(Clinic Schedule: Mon – Sat 8:00 AM – 6:00 PM)
1st Preference :
2nd Preference :

Do you have or had any physical or mental problem that may potentially affect your performance as a medical staff member?

( ) YES ( ) NO

Has any judgment or settlement been made against you in any professional liability case?

I hereby certify that all representations by me in this application form are true and correct. I have not knowingly withheld any fact or circumstances which would, if disclosed, affect my application unfavorably. I fully agree that any intentional misstatement in this form shall be grounds for disapproval/dismissal.

I understand and give consent to Fortmed Medical Clinics Makati, Inc. to conduct any inquiry request and receive any information concerning my character and reputation, including but not limited to, reports from any persons, schools, companies, corporations, partnerships, associations, law enforcement agencies, and any current or previous employers.

I further agree to release Fortmed Medical Clinics Makati, Inc., Inc. from any and all liability and responsibility arising out of the release of any such information.

(Signature above printed name)	SPECIMEN SIGNATURE (Please write in the middle)	(Date)