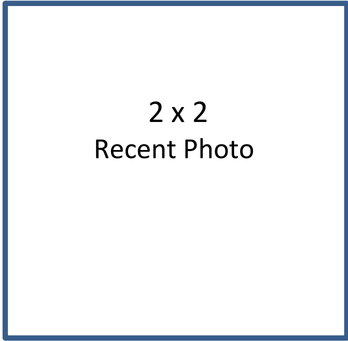
Chinese General Hospital and Medical Center
Department of Medical Education and Research

APPLICATION FOR POSTGRADUATE INTERNSHIP TRAINING PROGRAM

Year/ Batch ___________________



Name of Applicant: ___________________ ___________________ ___________
Last Name First Name Middle Name

Date of Birth: _________________ Birthplace: ___________________

Citizenship: __________________ Religion: ____________________

Gender: ☐ Male ☐ Female Language/Dialects Spoken: ______________

Marital Status: ___________ Number of dependents: ________________

Present Address: ____ Zip code: _________

Permanent Address: ____ Zip code: _________

Contact numbers: (Cellphone no.) ______________________________ Landline no: __________________

Email Address: ____

Whom to notify in case of emergency: ____

Permanent Address: ____

Relationship: ________________________ Contact number: _______________________

MEDICAL EDUCATION:

Medical School or University: ____________________________ Pre-Med Course: ________________

Honors or Awards: _________________________________ Date of Graduation: _____________

Other trainings: ______________________________________ Inclusive Dates: _________________

List of Hospitals in the order of your choice as submitted to your medical school

1. ____
2. ____
3. ____

What is your expectation after spending 1-year of Internship in this institution?

____

____

Describe yourself. List down your positive and negative attributes.

____

____

Fields of Interest: ____

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 _____________________

DMER-SD/FO-01
Rev. 5 March 1, 2021

(This part to be filled up by the Committee on Internship):

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

Recommendation: ☐ accept ☐ do not accept

Evaluators: ______________________________

____

Noted by: (CHAIR, COMMITTEE ON INTERSHIP) ______________________________

REQUIREMENTS:

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

- ☐ APMC Certification for Medical Internship & Pink Form
- ☐ Certification of Graduation / Medical School Diploma
- ☐ Complete transcript of Medical School
- ☐ Class Ranking
- ☐ 1 pc. 2x2 picture (colored)
- ☐ Official Result of Anti-HBsAg (within 6 months of application)
- ☐ Chest X-ray (result within 3 months of application)
- ☐ Curriculum Vitae
- ☐ Completely filled-up application form (download at CGHMC website)
- ☐ PhilHealth Membership ID Number / MDR
- ☐ Valid Good Clinical Practice (GCP) in Health Research