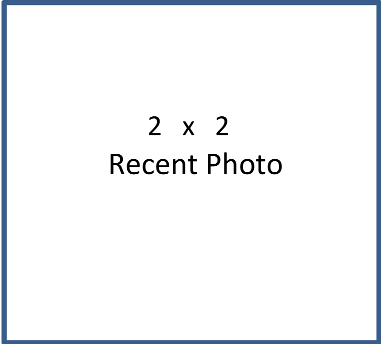
Chinese General Hospital and Medical Center
Department of Medical Education and Research

APPLICATION FOR FELLOWSHIP TRAINING PROGRAM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Subspecialty of Choice: ______________________

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: (Cellphone no) ____________________________ Landline #: ___________
Email Address: ___________________________________
Personal Identification:
TIN: ___________________________ PRC #: _____________ Valid until: _______________
PhilHealth Membership #: ___________ S2 #: _____________ Valid until: _______________
Other ____ 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 (i.e. USMLE, BQE, etc.) _________________________________
Postgraduate Internship: ____________________________ Inclusive Dates: ________________
Residency Training Program: _________________________ Inclusive Dates: ________________
Other trainings: _________________________________ Inclusive Dates: ________________

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-03
Rev. 5 March 1, 2021

(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) ________________________________

(Section Chair) ________________________________

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
- ☐ 1 pc. - 2x2 picture (colored)
- ☐ Letter of Intent
- ☐ (2) Two Recommendation Letters/ Character Reference from Dept. Head and Training Officer of Residency/ Fellowship Training Program except for Graduates of CGH 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
- ☐ Certificate of Residency Training Program *(Certified True Copy)*
- ☐ Certificate of Specialty Board Exam certifying diplomatic status
- ☐ Valid PRC License/ PRC ID
- ☐ TIN ID / BIR Form 2303
- ☐ Valid Professional Tax Receipt (PTR)
- ☐ CXR (PA, Lateral view) result done within 3 months of application
- ☐ HBsAg and Anti-HBs titer done within 6 months of application
- ☐ PhilHeatlh Membership ID Number / MDR
- ☐ Valid GCP
- ☐ Mental Health Certification (valid within 3 months before application) from a clinical psychologist or a licensed psychiatrist (especially if on medication)

For Applicants of Interventional Cardiology & Adult Echocardiography

- ☐ Certificate of Fellowship Training Program in Adult Cardiology
- ☐ Certificate of Philippine Specialty Board of Adult Cardiology from Philippine College of Cardiology

If available: (if not available, trainee will be required to attend during his/her training period with CGH)

- ☐ Valid Advanced Cardiac Life Support (ACLS) Certificate
- ☐ Valid Good Clinical Practice Certificate (GCP) in Health Research

**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.*