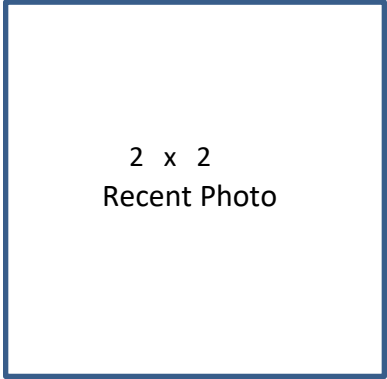




**APPLICATION FOR RESIDENCY TRAINING PROGRAM**



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)** \_\_\_\_\_

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**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)

*\*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.*