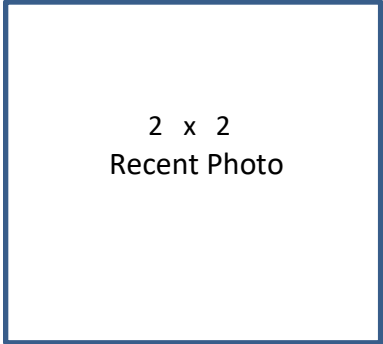




APPLICATION FOR FELLOWSHIP TRAINING PROGRAM



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 _____

(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
- PhilHealth 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)
- Immunization Record (If Available)
- Complete COVID-19 Vaccination Record

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.*