



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 _____

(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)

- Completely filled-up application form (download at CGHMC website)
- 1 pc. 2x2 picture (colored)
- Curriculum Vitae
- Complete transcript of Medical School
- Class Ranking
- Certification of Graduation / Medical School Diploma
- Official Result of Anti-HBsAg (within 6 months of application)
- Chest X-ray (result within 3 months of application)
- PhilHealth Membership ID Number / MDR
- Immunization Record (If Available)
- Complete COVID-19 Vaccination Record
- Valid Good Clinical Practice (GCP) in Health Research (If available)
- Valid ACLS/BLS Certificate (If available)