THE MEDICAL CITY
Where Patients are Partners
Ortigas Avenue, Pasig City, Philippines

DEPARTMENT OF ADVANCED MEDICAL EDUCATION

APPLICATION FORM

APPLYING FOR: ❒ Residency Training in _____ ❒ Fellowship Training in _____	**DATE APPLIED:**

PERSONAL DATA

NAME OF APPLICANT				**DATE OF BIRTH**			**PLACE OF BIRTH**
LAST NAME	FIRST NAME	MIDDLE NAME	NICKNAME	DD	MM	YYYY	

HOME ADDRESS *[Please indicate address at which you have maintained a permanent (legal) residence during the preceding 18 months]*	Tel No.:
	Mobile No.:
	Email Address:
PROVINCIAL ADDRESS	PRC No.:
	SSS No.:
	TIN No.:

Sex	Civil Status	Age	Citizenship	Religion
❒ Male ❒ Female	❒ Single ❒ Married ❒ Widow ❒ Separated			

Height	Weight	Any Distinguishing Marks: Hobbies/ Interests:

Father's Name	Age:	Occupation: Company:
Mother's Name	Age:	Occupation: Company:
If Married, Name of Spouse	Age:	Occupation: Company:

Brother(s) & Sister (s)	Age	Dependents	Age	Date of Birth
1.				
2.				
3.				
4.				
5.				

EDUCATIONAL BACKGROUND

	Name and Location of Institutions Attended	Inclusive Dates		Degree
		From:	To:	
Elementary:				
High School:				
College:				
Medical School:				

Post Graduate Internship (Hospital):	
Philippine Medical Licensure Examination Grade:	Date Taken:
Residency (Hospital):	Date Taken:
Specialty Board Exam:	Date Taken:
Where do you intend to practice in the future?	
Honors/ Awards Received:	
1.	
2.	
3.	
4.	
5.	

WORK/PROFESSIONAL EXPERIENCE
1.
2.
3.
4.

TRAININGS/SEMINARS ATTENDED
1.
2.
3.
4.

RESEARCH PAPERS DONE
1.
2.
3.
4.

MEDICAL INFORMATION	
1. Family History:	
2. Social History [Habits (tobacco, alcohol, substance used)]:	
3. Past Medical History:	
4. Past Surgeries:	
5. Blood Type:	
6. Primary Physician:	Hospital:

OTHER INFORMATION

1. Introduced/ Recommended by:

Name of Person/s	Contact Number	Name of Person/s	Contact Number

2. Have you ever been evaluated for behavioral or psychological reasons? ❒ Yes ❒ No
   If yes, state facts:

3. Have you ever been convicted of criminal offense? ❒ Yes ❒ No
   If yes, state facts:

4. Have you ever been dismissed, suspended, or placed on probation by any school/ hospital/ institutions? ❒ Yes ❒ No
   If yes, state facts:

5. Do you have any relative working for The Medical City? ❒ Yes ❒ No
   If yes, Give the name and Department he/she is in:

6. Have you travelled abroad or planning to go abroad? ❒ Yes ❒ No
   If yes, specify when, where and purpose: _____

_____

_____

7. In case of emergency, name of person/s to be notified:

Name of Person/s	Address	Contact Number
a.		
b.		
c.		

I will abide by the hospital's regulations concerning application deadlines and admission requirements. I hereby certify that the information which I have given is true and correct. Any misinterpretation of facts on this form may be sufficient grounds for the dismissal of my application/ employment even after I have been accepted. Should any of this information change, I shall notify the office of the Department of Advanced Medical Education (MTO) immediately.

In view of my application for appointment as trainee, I hereby authorized The Medical City and its duly authorized representative to verify, validate and authenticate may personal, educational and professional background, qualifications and eligibility. Moreover, persons government or private institutions and other entities who may have information as to my personal, moral, professional qualifications and competence to discharge my profession are hereby authorized to release whatever information that may have in connection with the above subject matter.

Furthermore, I authorized The Medical City to disclose to the person/s government/private institutions my identity and other information sufficient for The Medical City to make credible and authentic inquiries.

Finally, I release and discharge any person/s, government/ private institutions and entities who have released any information in reference to this undertaking.

_____

Signature Over Printed Name/ Date and Time

APPLICANT

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DEPARTMENT OF ADVANCED MEDICAL EDUCATION
APPLICANT'S CONSENT AND RELEASE

I, the undersigned, am applying for a ❑ residency/ ❑ fellowship training program with the Department of Advanced Medical Education (MTO).

I understand that as an applicant, I have the burden of producing adequate information for proper evaluation of my qualifications and for resolving any doubts about my qualifications. I understand that my application will not be processed until it is deemed complete by MTO.

I have the responsibility to keep my application current by informing MTO of any material change or addition to the information I have initially provided to this application of the filing of a lawsuit or other claims against me relating to my competency to practice my Profession. I will provide additional information that may be requested by the organization or its authorized representatives. My failure to provide the information requested, will prevent my application from being evaluated and acted upon.

I attest that the information included in this application is current, complete, accurate, and true. Any misrepresentation, misstatement, or omission from this application, whether intentional or not, may result in an automatic and immediate rejection of my application for appointment.

By applying for the residency/fellowship training program, I hereby:

- Agree to appear for an interview in regard to my application if required;
- Authorize MTO and their representatives to consult with administrators and members of other healthcare facilities/organizations of which I am or have been associated with, or any person who may have information related to my qualifications;
- Agree to provide a signature to assist in verifying my identity and credentials to other institutions;
- Agree that I have disclosed in my application all criminal convictions and any felony charges brought or pending against me. I further authorize MTO and its representatives to request individual, company, firm, corporation or public agency, including law enforcement agencies, to divulge, any criminal records or information, verbal or written, pertaining to me, including information or data received from other sources.

I hereby release from liability to the fullest extent permitted by law all representatives of The Medical City and its Medical/Professional staff for their acts performed and statements made in good faith and without malice within its scope as a review entity. I hereby release from liability any and all third parties who in good faith, and without malice, provide information to the facility/organization concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behaviour or any other matter that might have an effect on my competence, on patient care or on the orderly operation of any hospital or of The Medical City.

I agree to:

- Abide by the bylaws, rules and policies of The Medical City
- Abide by the residency/fellowship rules and regulation and the rules and policies of the department and/or clinical service to which I am assigned
- Adhere to recognized principles governing the practice of medicine, participate in continuing education program which relate, at least in part, granted to me by MTO, and document such participation when requested to do so;
- Observe the highest degree of morality in my relationship with my patients, colleagues and TMC personnel.
- Provide for care for my patients consistent with the standard of practice of my profession, accept committee assignments, accept administrative duties and participate in staffing emergency room service areas in my specialty on a reasonably agreed upon basis if requested to do so;
- Comply with applicable laws, including abstaining from the division of fees or remuneration for referrals under any guise whatsoever;
- Maintain a constructive interest and cooperate in advancing The Medical City as a quality healthcare facility/organization; and;
- Seek consultation by physicians of appropriate clinical experience as needed or requested.

I acknowledge that residency/fellowship training program at MTO are not a right of every licensed professional who makes application for the same.

I understand that:

- My application will be evaluated in accordance with prescribed procedures defined in the residency/fellowship training program.
- All medical staff recommendations relative to my application are subject to the ultimate action of MTO;
- If appointed, my initial appointment shall be provisional for the time period determined by Department of Advanced Medical Education; reappointment remain contingent upon my continued demonstration of professional competence and cooperation, acceptable performance of all responsibilities, as well as the other factors deemed relevant by MTO.
- The provisions of the rules and regulations relating to confidentiality and release from liability are express conditions of my application for residency/fellowship training program.

_____

Signature Over Printed Name / Time and Date
APPLICANT