IntelliHealth
Your health is our top priority.

DEPARTMENT OF ADVANCED MEDICAL EDUCATION

APPLICATION FORM

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

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	❒ Single	❒ Married			
❒ Female	❒ 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