SOUTHERN PHILIPPINES MEDICAL CENTER
J.P. Laurel Ave., Bajada, Davao City

PERSONNEL HEALTH SERVICES (PHS) REGISTRATION FORM

Date of joining: _____ HRN: _____

Name of Employee: _____
Last Name First Name Middle Name

Job Function: _____ License No.: _____ SPMC ID/item No.:_____

Department /Ward: _____ Biometric ID No.: _____

TIN: _____ Contract Started: _____

Employment Status (Please Check Contract Type): ( ) Plantilla ( ) Job Order ( ) Auxiliary

( ) Volunteer/Visiting ( ) Retiree ( ) Detailed (Specify): _____

If Volunteer/Visiting:
PHIC Accreditation No.:_____ Expiration Date: ____/____/____

Encoded by: _____
(Name of IHOMP Staff / Signature / Date)

Remarks : ***If Category III:***
- ☐ Category I
- ☐ Category III
- ☐ Category IV

Approved by: _____
(Section Head/Signature/Date)

Time Started: _____ AM/PM Verified by: _____
Time Ended: _____ AM/PM (Client's Name / Signature / Date)

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