



UNIVERSITY OF CEBU MEDICAL CENTER

Ouano Ave., North Reclamation Area, Mandaue City

Tel No. (032) 517.0888

APPLICATION FORM FOR RESIDENCY TRAINING PROGRAM

Department: _____

Name: (Family)	(First)	(Middle)	PRC NUMBER :
----------------	---------	----------	--------------

Date of Birth:	Age:	Status:	Nationality:
----------------	------	---------	--------------

Height:	Weight:	Sex
---------	---------	-----

Spouse:	Number of Children:
---------	---------------------

Mailing Address:	Email Address:	Mobile Number:
------------------	----------------	----------------

In case of Emergency notify:		
Name:	Relation to Applicant	Contact Number

Any important medical or health problems? (e.g. Allergies, Arthritis, Tuberculosis, Asthma, Diabetes, Hypertension, etc.)

Employment Records (Please provide information about your last 3 jobs starting with the most recent)

Name of Company:	Position:	Date of Employment:	Reason for leaving:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Educational Attainment (Please separate sheets if necessary)

<u>Name of Institution</u>	<u>Location</u>	<u>Inclusive Date</u>	<u>Degree</u>
College: _____	_____	_____	_____
Medical School: _____	_____	_____	_____
Post Graduate School: _____	_____	Year: _____	_____
Licenses, Certificate, Professional Membership, etc.: _____			
Are you taking advance studies? (If yes, please specify the program you are taking): _____			



UNIVERSITY OF CEBU MEDICAL CENTER

Ouano Ave., North Reclamation Area, Mandaue City

Tel No. (032) 517.0888

Please state the reason for applying in this hospital:

If given a chance to work here, are you willing to uphold the high moral and ethical principles of this Hospital? _____

Would you be willing to abide with the policies, rules and regulations of this hospital and participate in its activities? _____

Are you willing to sign contract to work here for at least one year? _____

Please give me the names of three persons who can vouch your character and integrity:

Name	Address	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby certify that all above statement is true and correct to the best of my knowledge. If employed, I promise to give my honest and unstinted loyalty to University of Cebu Medical Center (UCMed). In witness hereof I sign my name below.

Signature of Applicant

Date

Recommendation:

Department Head

Chairman Credentials Committee

Requirements

1. Filled out Application Form
2. Medical School Diploma
3. Transcript of Records
4. PRC ID
5. PRC Board Certificate
6. Certificate of Class Ranking
7. Board Rating
8. Post Graduate Internship Training Certificate
9. Letter of Intent Addressed to the Chairman of the Department
Anesthesiology: Dr. Robinson C. Lui
Family & Community Medicine: Dr. Roxanne Bongon
Internal Medicine: Dr. Nello Bayani IV R. Roa Jr.
Obstetrics/Gynecology: Dr. Mary Girlie Veloso-Borromeo
Orthopedics: Dr. Pierre M. Mella
Pediatrics: Dr. Nathalie Anne Silvestra R. Hernaez
Radiology: Dr. Faith Caroline Bayabos
Surgery: Dr. Maribel Du
10. Recommendation Letter from the Dean
11. 2 Pcs 2x2 colored pictures with white background

For Inquiries contact :

0925 558 9824 or 0977 809 6788
(032) 517.0888 local 5100