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)*

	Name of Institution	*Location*	*Inclusive Date*	*Degree*
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): _____

_____

Please state the reason for applying in this hospital:

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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. Teodulo San Juan*
   - ***Family Medicine**: Dr. Florentino Berdin Jr.*
   - ***Internal Medicine**: Dr. Lamberto Garcia Jr.*
   - ***Obstetrics/Gynecology**: Dr. Virginia Villegas*
   - ***Orthopedics**: Dr. Jose Flordelis*
   - ***Pediatrics**: Dr. Nathalie Anne Hernaez*
   - ***Surgery**: Dr. Joselito Almendras*
10. *Recommendation Letter from the Dean*
11. *2 Pcs 2x2 colored pictures with white background*

For Inquiries contact : Ms. Kay Flores
0925 558 9824 or 0977 809 6788
(032) 517.0888 local 5100