



# 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 :
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Date of Birth:	Age:	Status:	Nationality:
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Height:	Weight:	Sex	
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Spouse:		Number of Children:	
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Mailing Address:		Email Address:	Mobile Number:
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**In case of Emergency notify:**

Name:	Relation to Applicant	Contact Number
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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):	_____			
	_____			



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Please state the reason for applying in this hospital:

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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. Darwin James Alvarez  
**Family & Community Medicine:** Dr. Roxanne Bongon  
**Internal Medicine:** Dr. Lamberto Garcia Jr.  
**Obstetrics/Gynecology:** Dr. Mary Girlie Veloso-Borromeo  
**Orthopedics:** Dr. Jose Flordelis  
**Pediatrics:** Dr. Nathalie Anne Silvestra 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, please contact:

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