PAHMOC

PHYSICIAN APPLICATION AND INFORMATION SHEET

I have read, understood and agreed to all provisions of the PAHMOC MOA covering the period September 01, 2021 to August 31, 2023 and wish to apply for inclusion therein. If approved, I understand that the Unified Service Agreement (USA) that shall be issued to me by PAHMOC and will automatically terminate upon the termination of contract with the accredited society.

A. PERSONAL DATA

NAME: ______________________ ______________________ ______________________

First Name   Middle Name   Surname

BIRTHDATE: ______________________ GENDER __________ STATUS __________

PREFERRED MAILING ADDRESS

HOME ____

HOSPITAL ____

EMAIL ADDRESS ____

CONTACT NO/S. (Please include Mobile No./s) ____

B. PROFESSIONAL DATA

SPECIALTY ______________________ [ ] FELLOW [ ] DIPLOMATE [ ] MEMBER

SUB-SPECIALTY ______________________ [ ] FELLOW [ ] DIPLOMATE [ ] MEMBER

PRC NO. ______________________ TIN ______________________

PHIC NO. ______________________ VALID FROM __________ UP TO __________

C. HOSPITAL/CLINIC AFFILIATION (WITH REGULAR CLINIC SCHEDULE)

	HOSPITAL/CLINIC NAME	ROOM NO.	SCHEDULE (DAY-TIME)
1.)	______________________	__________	Sun ____ M_____ T_____ W______ Th_____ F_____ Sat_____
2.)	______________________	__________	Sun ____ M_____ T_____ W______ Th_____ F_____ Sat_____
3.)	______________________	__________	Sun ____ M_____ T_____ W______ Th_____ F_____ Sat_____
4.)	______________________	__________	Sun ____ M_____ T_____ W______ Th_____ F_____ Sat_____
5.)	______________________	__________	Sun ____ M_____ T_____ W______ Th_____ F_____ Sat_____

D. OTHER HOSPITAL/CLINIC (VISITING)

	HOSPITAL/CLINIC NAME	ROOM NO.	SCHEDULE (DAY-TIME)
1.)	______________________	__________	Sun ____ M_____ T_____ W______ Th_____ F_____ Sat_____
2.)	______________________	__________	Sun ____ M_____ T_____ W______ Th_____ F_____ Sat_____
3.)	______________________	__________	Sun ____ M_____ T_____ W______ Th_____ F_____ Sat_____
4.)	______________________	__________	Sun ____ M_____ T_____ W______ Th_____ F_____ Sat_____
5.)	______________________	__________	Sun ____ M_____ T_____ W______ Th_____ F_____ Sat_____

I hereby agree to be affiliated in all hospitals and clinics written in this form.

I certify that all my information written above are TRUE and CORRECT.

I give my consent to the PAHMOC to gather, use, share, store, and dispose of my personal and sensitive information in keeping with the Data Privacy Act of 2013.

______________________________ ______________________

Physician Signature over Printed Name   Date

APPROVING OFFICERS (NAME AND SIGNATURE)

PPS   PAHMOC

______________________________ ______________________________

Chapter President's Signature over Printed Name   Authorize Representative's Signature over Printed Name

NOTE: ATTACHED ARE THE FOLLOWING DOCUMENTARY REQUIREMENTS

_______ BIR Certificate of Registration (Form 2303)   _______ Curriculum Vitae

_______ Updated PRC ID   _______ Diplomate/Fellow Certificate

_______ Updated PHIC ID   _______ Signed Data Privacy Consent Form

(Revision 01_Dec. 2020)