



APPLICATION FOR WRITTEN EXAMINATION ONLY

Please read the General Information and Checklist of Requirements for the PPS Certifying Examinations, available at the PPS Website, before accomplishing this application form. This application form must be accompanied by supporting documents.

Fill in ALL blanks and boxes. TYPE or PRINT IN BLOCK LETTERS all responses. Type or Print "NA" if not applicable.

Name _____ Sex _____ Status _____
 (Surname) (First Name(s)) (Middle Name)

Birthplace _____ Date of Birth _____ PRC ID Number: _____

Home Address _____ PhoneNo. _____

Office Address _____ PhoneNo. _____

Mailing Address (choose one) Home OR Office Email address: _____ Mobile No. _____

Medical School Graduated _____ Year Graduated: _____

I. Pediatric Residency Training

*Write Chief Resident if that was your designation in your training insitution.

	Institution	Designation*	Date started mm/dd/yr	Date completed mm/dd/yr	Department Chair
A. Residency Taining (Local & Abroad)					

II. Research Works, Papers, Publications or Thesis (use another sheet of paper, if needed)

Title/Author(s):	<input type="checkbox"/> Published <input type="checkbox"/> Unpublished	<input type="checkbox"/> Senior Author <input type="checkbox"/> Co-Author	Year Completed or Published
Title/Author(s):	<input type="checkbox"/> Published <input type="checkbox"/> Unpublished	<input type="checkbox"/> Senior Author <input type="checkbox"/> Co-Author	Year Completed or Published

III. Summary of CPD units earned - at least 25 CPD units earned per year in addition to PPS Annual Convention (from most recent three years, use extra sheets if necessary). Graduates of residency within the 12 months of application need not show CPD units earned.

Year	PPS Annual Convention	Number of Other CPD Units Earned

IV. Information on Previously Taken Specialty Board Examination(s)

Is this the first time you will take the Certifying Written Examination?

Yes No If you answered NO, PLEASE FILL UP THE DATES WHEN YOU TOOK THE WRITTEN EXAMINATION

Date of First Exam	Date of Second Exam	Date of Third Exam	Date of Fourth Exam

I attest that the information provided is true and accurate to my best knowledge.

 Name and Signature of Applicant

 Date of Application

***IMPROPERLY FILLED-UP FORM SHALL NOT BE ACCEPTED**

FOR THE SPECIALTY BOARD USE ONLY

Date Received _____

Date of Deliberation _____

Action Taken: Approved Disapproved

Remarks _____

 SB Examiner

 SB Secretary

 SB Chair