PHILIPPINE PEDIATRIC SOCIETY(PPS) and the ASSOCIATION OF HEALTH MAINTENANCE ORGANIZATIONS OF THE PHILIPPINES, INC. (AHMOPI)
January 1, 2024 to December 31, 2026 MEMORANDUM OF AGREEMENT
APPLICATION, UNDERTAKING AND INFORMATION SHEET OF THE PHYSICIAN
(Please print legibly, completely and submit/email form to the PPS Secretariat ppsinc@pps.org.ph)

I have read, understood and agreed to all the provisions of the PPS – AHMOPI Memorandum of Agreement, Implementing Rules and Regulations and Unified Service Agreement (MOA, IRR & USA) and wish to apply for inclusion therein. If approved, I understand that the Unified Service Agreement that shall be issued for and in my behalf by the PPS & the AHMOPI will automatically terminate on December 31, 2026. Through this undertaking and my signature below, I likewise give my full consent to the PPS & the AHMOPI to gather, use, share, store and dispose of my personal and sensitive data in keeping with provisions of the Data Privacy Act of 2012 and its IRR and the National Privacy Commission's directives and issuances and for the PPS-AHMOPI MOA, IRR & USA purposes only.

A. PERSONAL DATA:

_____
FIRST NAME MIDDLE NAME SURNAME

BIRTHDATE : _____ GENDER [ ] Male [ ] Female STATUS _____

PREFERRED MAILING ADDRESS: HOSPITAL _____

HOME _____

EMAIL ADDRESS : _____ MOBILE NO/S. _____

B. PROFESSIONAL DATA:

SPECIALTY _____ [ ] DIPLOMATE [ ] FELLOW

SUBSPECIALTY _____ [ ] DIPLOMATE [ ] FELLOW

PRC NO. _____ PMA NO. _____

PHIC MEMBER NO. _____ PHIC PROVIDER NO. _____

TIN _____ BIR Registration: [ ] VAT Registered (Please. submit photocopy of VAT Registration Cert .[ ] Non-VAT

C. CLINIC/HOSPITAL AFFILIATIONS (WITH REGULAR CLINIC SCHEDULES)

	CLINIC/HOSPITAL	ADDRESS	CLINIC SCHEDULE	CONTACT NOS.
1.				
2.				
3.				
4.				
5.				

D. OTHER HOSPITAL AFFILIATION/S (VISITING)

	HOSPITAL	ADDRESS	CLINIC SCHEDULE	CONTACT NOS.
1.				
2.				
3.				
4.				
5.				

E. KINDLY ANSWER THE FOLLOWING:

	YES	NO
1. DO YOU WANT TO BE ACCREDITED FOR ALL YOUR HOSPITAL AFFILIATIONS?	[ ]	[ ]
2. IF NOT, WHAT HOSPITALS? DO YOU HAVE CLINIC IN THESE HOSPITALS?		
a. _____	[ ]	[ ]
b. _____	[ ]	[ ]
c. _____	[ ]	[ ]
d. _____	[ ]	[ ]
e. _____	[ ]	[ ]

SIGNATURE OF PHYSICIAN: _____ **DATE:** _____

APPROVING OFFICERS (NAME & SIGNATURE)

PPS:

_____ /Date: _____

_____

AHMOPI:

Carlos D. Da Silva _____ / Date: _____

Executive Director

(Form 01 January 2024)