Philippine College of Surgeons

APPLICATION FORM

NAME: _____ STATUS:_____

DATE & PLACE OF BIRTH: _____ SEX: _____

EMAIL ADDRESS: _____ MOBILE NO: _____

RESIDENCY TRAINING PROGRAM (Hospital with Complete Address):

_____

YEAR LEVEL:_____ DURATION OF TRAINING:_____

TEL NO: _____

HOME ADDRESS (Complete): _____

TEL. NO: _____

MEDICAL SCHOOL: _____ YEAR: _____

INTERSHIP: _____ YEAR: _____

PHIL. MEDICAL BOARD CERTIFICATE NO.: _____ DATE: _____

FELLOWSHIPS: (**Specialty**, **Date, Hospital, Year Level**)

_____

REFERENCES: (PCS Fellows only)

1. _____ 2. _____

I hereby attest to the truthfulness of all the information contained in this application. I acknowledge that any false statement or misrepresentation made herein shall be sufficient cause for the forfeiture of my application fee and will only allowed to re-apply for membership after two (2) years.

DATE: _____ SIGNATURE: _____

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Fax no: (632) 929-2297 **E-mail:** secretariat@pcs.org.ph **Website:** http://www.pcs.org.ph