PHILIPPINE COLLEGE OF SURGEONS and the ASSOCIATION OF HEALTH MAINTENANCE ORGANIZATIONS OF THE PHILIPPINES, INC.
January 1, 2019 to December 31, 2021 MEMORANDUM OF AGREEMENT

APPLICATION, UNDERTAKING AND INFORMATION SHEET ON THE PHYSICIAN

(PLEASE PRINT LEGIBLY AND COMPLETE THIS FORM IN FULL)

I have read, understood and agreed to all the provisions of the PCS-AHMOPI MOA, IRR AND 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 PCS & the AHMOPI will automatically terminate on December 31, 2021. Through this undertaking and my signature below, I likewise give my full consent to the PCS & the AHMOPI to gather, use, share, store and dispose of my private and sensitive data in keeping with provisions of the Data Privacy Act of 2012 and its IRR and the National Privacy Commission's issuances and for the PCS-AHMOPI MOA, IRR & USA purposes.

A. PERSONAL DATA:

NAME : ____

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)

PCS:

____________________ /Date: ____________

____

AHMOPI:

Carlos D. Da Silva ____________ / Date: ____________

Executive Director

(Form 01 January 2019)