



**PHILIPPINE COLLEGE OF SURGEONS and the ASSOCIATION OF HEALTH
MAINTENANCE ORGANIZATIONS OF THE PHILIPPINES, INC.**
February 1, 2022 to December 31, 2024 MEMORANDUM OF AGREEMENT
APPLICATION, UNDERTAKING AND INFORMATION SHEET OF THE PHYSICIAN
(PLEASE PRINT LEGIBLY AND COMPLETE THIS FORM IN FULL)



I have read, understood and agreed to all the provisions of the Philippine College of Surgeons (PCS) – Association of Health Maintenance Organizations of the Philippines, Inc. (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 to the current PCS president, for and in my behalf, by the AHMOPI will automatically terminate on December 31, 2024. 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 only.

A. PERSONAL DATA:

BIRTHDATE : _____ FIRST NAME _____ MIDDLE NAME _____ SURNAME _____
 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