PHILIPPINE COLLEGE OF SURGEONS &
PHILIPPINE ASSOCIATION OF HEALTH
MAINTENANCE ORGANIZATION COMPANIES

PHYSICIAN APPLICATION AND INFORMATION SHEET

I have read, understood and agreed to all provisions of the PAHMOC MOA covering the period _____ and wish to apply for inclusion therein. If approved, I understand that the Unified Service Agreement (USA) that shall be issued to me by PAHMOC and will automatically terminate upon the termination of contract with the accredited society.

A. PERSONAL DATA

NAME: _____
First Name Middle Name Surname

BIRTHDATE: _____ GENDER: _____ STATUS: _____
mm/dd/yy

PREFERRED MAILING ADDRESS

HOME _____

HOSPITAL _____

EMAIL ADDRESS: _____ CONTACT NO/S.: _____
(Please include Mobile No./s)

B. PROFESSIONAL DATA

SPECIALTY _____ [ ] FELLOW [ ] DIPLOMATE [ ] MEMBER

SUB-SPECIALTY _____ [ ] FELLOW [ ] DIPLOMATE [ ] MEMBER

PRC NO. _____ TIN NO. _____

PHIC NO. _____ VALID FROM _____ UP TO _____

C. HOSPITAL/CLINIC AFFILIATION (WITH REGULAR CLINIC SCHEDULE)

	HOSPITAL/CLINIC NAME	ROOM NO.	SCHEDULE (DAY-TIME)
1)	_____	_____	Sun_____ M_____ T_____ W_____ Th_____ F_____
2)	_____	_____	Sun_____ M_____ T_____ W_____ Th_____ F_____
3)	_____	_____	Sun_____ M_____ T_____ W_____ Th_____ F_____
4)	_____	_____	Sun_____ M_____ T_____ W_____ Th_____ F_____
5)	_____	_____	Sun_____ M_____ T_____ W_____ Th_____ F_____

D. OTHER HOSPITAL/CLINIC (VISITING)

	HOSPITAL/CLINIC NAME	ROOM NO.	SCHEDULE (DAY-TIME)
1)	_____	_____	Sun_____ M_____ T_____ W_____ Th_____ F_____
2)	_____	_____	Sun_____ M_____ T_____ W_____ Th_____ F_____
3)	_____	_____	Sun_____ M_____ T_____ W_____ Th_____ F_____

I hereby agree to be affiliated in all hospitals and clinics written in this form.
I certify that all my information written above are TRUE and CORRECT.
I give my consent to the PAHMOC to gather, use, share, store, and dispose of my personal and sensitive information in keeping with the Data Privacy Act of 2013.

_____ _____
Physician Signature over Printed Name Date

APPROVING OFFICERS (NAME AND SIGNATURE)

PCS

RAMON S. INSO, MD
President

PAHMOC

_____
Authorize Representative's Signature over Printed name

NOTE: ATTACHED ARE THE FOLLOWING DOCUMENTARY REQUIREMENTS

_____ BIR Certificate of Registration (Form 2303)
_____ Updated PRC ID
_____ Updated PHIC ID
_____ Curriculum Vitae
_____ Diplomate/Fellows Certificate
_____ Signed Data Privacy Consent Form