Philippine College of Surgeons

REQUIREMENTS FOR RESIDENTS' MEMBERSHIP

1. Accomplished Application form and notarized Waiver
2. Certified true copy of Photocopy of updated/valid Professional Identification Card issued by PRC
3. Certified true copy of Medical School Diploma
4. Endorsement letter from Department Chairman and Training Officer of the Accredited Training Program / institution attesting to his / her Residency
5. Two (2) 2x2 colored pictures
6. Onetime application fee Php500.00

CRITERIA FOR ELIGIBILITY

1. Resident or Fellow in a Surgical Training Program of an Accredited Training Program in any surgical specialty
2. Good standing in their specialty society resident organization
3. Have completed residency and entering Fellowship in Surgical Training Program

BENEFITS

1. Avail of Resident's rates during PCS Conventions
2. Eligibility for PCS scholarship program
3. Resources for research
4. Avail of Workshops conducted by PCS (its local Chapter/or Specialty Societies)
5. Access to PJSS
6. Membership to certain PCS Committee as Resident representatives (non-voting capacity)
7. Resident's Award

MEMBERSHIP ENDS

1. Upon graduation from residency/fellowship program
2. Removal from residency program

*For your convenience, the following payment options will be accepted by the College:

1. Cash
2. Personal checks, payable to the **PHILIPPINE COLLEGE OF SURGEONS, INC.**
3. Inter-branch deposits (IBD) may be made thru: **PCS Banco De Oro Savings Account No. 00 405 000 4510**
4. Email your proof of payment to membership@pcs.org.ph

4th Floor, PCS Building 992 EDSA, Quezon City, Philippines 1005 (Near SM North EDSA)
Mobile nos: ; 0917-5471936 **C/O Yeye Geronimo** **E-mail:** secretariat@pcs.org.ph **Website:** http://www.pcs.org.ph

Philippine College of Surgeons

APPLICATION FORM FOR RESIDENT MEMBER

NAME: ____ STATUS: ______________

DATE & PLACE OF BIRTH: ______________________________ SEX: ______________

EMAIL ADDRESS: ______________________________ MOBILE NO: ______________

RESIDENCY TRAINING PROGRAM (Hospital with Complete Address):

____

YEAR LEVEL: __________ DURATION OF TRAINING: ______________________________
(Date started – Date end)

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: ______________________