PHILIPPINE OBSTETRICAL AND GYNECOLOGICAL SOCIETY (Foundation), INC.
COMMITTEE ON MUTUAL ASSISTANCE PROGRAM
SICKNESS BENEFIT PROGRAM

SBP Form

Date: _____

Name of Applicant: _____

Age: _____

Address: _____

Contact Nos. Telephone No. _____ Mobile No. _____

POGS-MAP Member in Good Standing Yes ☐ No ☐

Membership Category: ☐ Fellow ☐ Diplomate ☐ Junior ☐ Associate

Hospital confinement:

Where: _____

Dates: _____

Diagnosis: _____

Operation: _____

Attending physician:

Print Name: _____ Signature: _____

License No. _____ PTR: _____

_____
Signature of Applicant

Attachments: (Certified True Copy)
1. Discharge Summary 2. Operative records (if applicable)

Action Taken:

CMAP Recommending:

Approval ☐
Disapproval ☐

Validating Officer:

_____
Signature over printed name

Date signed: _____

POGS SBP
APPLICATION RECEIVED BY:
DATE RECEIVED:

Mutual Assistance Program

_____
Chair

Date signed: _____

BOT ACTION

Approved ☐ Disapproved ☐

_____
President