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

LIVING BENEFIT PROGRAM (LBP)
APPLICATION FORM

To be accomplished by the POGS MAP Member or member of the family:

Date of application ____

Name of Member Applicant ____

Address ____

Age: ______ Date of Birth _________________ Contact Numbers ______________________

Contact Person ______________________________Relation to the member_____________________

____
Signature of applicant / Contact Person

Please be reminded that by submitting to us your personal information, you consent to the processing of your personal information by POGS for the purposes as stated in our privacy policy. For a more detailed information on this policy, kindly visit our website: www.pogsinc.org

To be accomplished by the Attending Physician:

Disability / Illness ____

Duration of Illness ____

Present Condition ____

Procedure(s) performed ____
____

Remarks ____

I HEREBY CERTIFY that the above information is true and correct to the best of my knowledge:

Name of Attending Physician: ____

License No. ___________ Signature ____________________ Date signed: ______________

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COMMITTEE AND BOT ACTION

CMAP	**CHAIR**	**PRESIDENT**
Recommending approval ☐ Disapproved ☐	Remarks: __________________	☐ Approved ☐ Disapproved
CMAP Validating Officer Date signed: ______________	CMAP CHAIR Date signed: ______________	POGS President Date signed: ______________