PHILIPPINE OBSTETRICAL & GYNECOLOGICAL SOCIETY and the ASSOCIATION OF HEALTH MAINTENANCE ORGANIZATIONS OF THE PHILIPPINES, INC.
January 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 Obstetrical & Gynecological Society (POGS) – 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 POGS 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 POGS & 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 POGS-AHMOPI MOA, IRR & USA purposes only.

A. PERSONAL DATA:

_____
FIRST NAME MIDDLE NAME SURNAME

BIRTHDATE : _____ 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)

POGS:

_____ /Date: _____

AHMOPI:

Carlos D. Da Silva _____ / Date: _____
Executive Director