**PHILIPPINE OBSTETRICAL AND GYNECOLOGICAL SOCIETY (Foundation), INC PHILIPPINE BOARD OF OBSTETRICS AND GYNECOLOGY**

**RESIDENCY TRAINING PROGRAM:**

 **from to .**

*Name of Institution*

*Chairman*

*Date started*

*Date Ended*

 **\_ from to \_ \_ .**

*Name of Institution Chairman Date started Date Ended*

 **\_ from to \_ \_ .**

*Name of Institution Chairman Date started Date Ended*

**Attested by:**

**Chairman of OB-GYN Department/ Hospital Director**

# No. 56 Malakas Street, Diliman, Quezon City 1100

Tel Nos: 89220195; 89217647 Loc. 209 Fax Nos: 89219089

# Email Address: pogsinc@gmail.com; pbog2010@gmail.com website: [www.pogsinc.org](http://www.pogsinc.org/)

INSTRUCTIONS:

1. ACCOMPLISH THE APPLICATION FORM COMPLETELY
2. PRINT DATA LEGIBLY IN CAPITAL LETTERS

**PART I (WRITTEN EXAMINATION)**

**APPLICATION FORM**

|  |
| --- |
| **NAME *(Family Name) ( First Name) (Middle Name)*** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**RESIDENCE / HOME ADDRESS** *(No., Street, Brgy., Town, Municipality/ City, Province, Zip code)* **REGION**

**MAIN HOSPITAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLINIC ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

POGS REGION

2 Passport size (1.5"x2") photo taken within

3 months with FULL nametag

 Scanned, computer- generated / enhanced,

SPECIALTY

SUBSPECIALTY

GENERAL PRACTICE:

 Private Government

photocopied, cutout, and pictures without nametag

are not accepted

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **BIRTH DATE***(MM/DD/YY)* | **CIVIL STATUS** | **GENDER*****(****F / M)* | **CITIZENSHIP** | **PRC NUMBER** |  |  |  |  |  |  | **DATE OF LICENSURE** |  | **PMA NUMBER** |  |  |  |  |  |  |

HOME NO.

MOBILE NO.

CLINIC NO. (Main)

EMAIL ADDRESS

MEDICAL SCHOOL ATTENDED: YEAR GRADUATED

**Signature**

**REGIONAL DIRECTOR:**

**Name**

I respectfully apply for certification as **JUNIOR MEMBER** In OBSTETRICS AND GYNECOLOGY by the PHILIPPINE BOARD OF OBSTETRICS AND GYNECOLOGY

**SIGNATURE OVER PRINTED NAME**

**PREVIOUS PBOG EXAMS TAKEN**

**PART II (ORALS)**

**DATE**

**OUTCOME**

**PART I (WRITTEN)**

**POSTGRADUATE COURSES/ ADVANCED TRAINING ATTENDED** *(In the last 3 years)*

|  |  |  |  |
| --- | --- | --- | --- |
| **CONVENTION**  | **PLACE** | **DATE** | **CME UNITS** |
|  |  |  |  |
|  |  |  |  |

TEACHING POSITIONS:

|  |  |  |
| --- | --- | --- |
| **PRESENT POSITION** | **SCHOOL** | **DATE** |
|  |  |  |
|  |  |  |

MEDICAL SOCIETY MEMBERSHIP

 from to

 from to

**ENDORSED BY 3 POGS FELLOWS:**

**NAME SIGNATURE INSTITUTION**

1.

2.

3.

I, , hereby certify to the correctness of the information stated above and confirm my consent to the POGS to process my information/data for the purposes stated on the privacy policy of the Society. In witness thereof, I hereunto set my signature this day of , 20 .

 Signature over printed name

Do not fill-up below this line

ACCOUNTING SECTION:

Date: Application O.R. No. Amount Date: Examination O. R. No. Amount: Date:

Printed Name and Signature of Processor

***Chairman, PBOG***