Arrangement in Sequence of Part II
Oral Examination Requirements For
First Time Application

CHECKLIST		
Cover page – TITLE: "Requirements for Diplomate Part II" (New Application) Name of Applicant _____Date of Submission _____		
General Table of Contents – List of the sequence in which the requirements are arranged in the compilation; PAGE NUMBER is required on ALL pages.		
Application Form (*Refer to Appendix D2*)	Completely filled out (with most recent picture, signatures of applicant, Regional Director EXCEPT NCR RD, and three POGS Fellows endorsing the applicant)	
Certificates	Jurat Notarization (this is a **CORE** requirement). *Refer to Appendix E.*	
	Certificate of POGS Junior Membership (must be within the validity period of 5 years)	
	Certificate of Completion or Diploma of Residency Training.	
	Certificate of Good Standing from PMA or its component society.	
	Updated valid PRC ID.	
	Certification of authenticity of cases, from the Department Chair AND the Medical Director that submitted cases were admitted and performed by the applicant	
Major Cases	**Ten (10) Major Cases**, consisting of: • 6 Major Obstetric cases • 4 Major Gynecologic cases	

	Correct number is a **CORE requirement**. *Refer to Appendix F for List of Major Cases.* Variety of cases and indications is a **CORE requirement**. Cases should be done as within two (2) years from the time of application, after residency training and with the applicant as the PRIMARY SURGEON. (Cases done during Fellowship are accepted.) TABULATION OF CASES/PROCEDURES with seven columns (in ARIAL font 12 pt, landscape view) • Tally number, Patient's age and OB score, Date admitted, Date discharged, Hospital where procedure was done • Admitting Diagnosis • Pre-operative Diagnosis • Management, Operation/Procedure done, Anesthesia done, Date done • Indication for Surgery/Procedure (INCLUDE Justification if there is deviation from standard of care)) DO NOT leave this column blank. DO NOT copy pre-operative diagnosis. • Final Diagnosis • Patient/Maternal/Fetal Outcome/Histopathology result	
	Supporting Documents – arranged following the sequence in "Tabulation of Cases/Procedures" and correctly labelled with the tally number stated in the tabulation (OB1, OB2, OB3… GYN1, GYN 2…) • Operative Record – applicant types the EXACT contents of the Operative Record, but omits patient identifiers. (Typewritten in Arial font 12 pt, portrait view) The type of anesthesia used and duration of surgery must be stated. • Operative Technique • Partogram (for all dystocia and failed induction cases) • Histopathology Report, if applicable - applicant types the EXACT contents of the histopathology report, with gross and microscopic descriptions but omits patient identifiers. (Typewritten in Arial font 12 pt, portrait view and stamped Certified True	

	Copy by the Records Section or Department of Pathology) Applicant to follow **DATA PRIVACY POLICY:** Typewritten copies of Operative Technique (with findings) and Histopathology Report (if applicable in case/s) are submitted WITHOUT PATIENT IDENTIFIERS such as Name and Case number (anonymized data).	
Minor Cases	**Ten (10) Minor Cases,** consisting of: • 5 minor Obstetric cases • 5 minor Gynecologic cases Correct number is a **CORE requirement**. *Refer to Appendix G for List of Minor Cases.* Variety of cases and indications is a **CORE requirement**. Cases should be done within two (2) years from the time of application, after residency training and with the applicant as the PRIMARY SURGEON. (Cases done during Fellowship are accepted.) TABULATION OF CASES/PROCEDURES with seven columns (in ARIAL font 12 pt, landscape view) • Tally number, Patient's age and OB score, Date admitted, Date discharged, Hospital where procedure was done • Admitting Diagnosis • Pre-operative Diagnosis • Management, Operation/Procedure done, Anesthesia done, Date done • Indication for Surgery/Procedure (INCLUDE Justification if there is deviation from standard of care) DO NOT leave this column blank. DO NOT copy pre-operative diagnosis. • Final Diagnosis • Patient/Maternal/Fetal Outcome/Histopathology result	
	Supporting Documents – arranged following the sequence in "Tabulation of Cases/Procedures" and correctly labelled with the tally number stated in the tabulation (OB1, OB2, OB3… GYN1, GYN 2…)	

	• Operative Record – applicant types the EXACT contents of the Operative Record, but omits patient identifiers. (Typewritten in Arial font 12 pt, portrait view) The type of anesthesia used and duration of surgery must be stated. • Operative Technique • Histopathology Report, if applicable - applicant types the EXACT contents of the histopathology report, with gross and microscopic descriptions but omits patient identifiers. (Typewritten in Arial font 12 pt, portrait view and stamped Certified True Copy by the Records Section) Applicant to follow **DATA PRIVACY POLICY:** Typewritten copies of Operative Technique (with findings) and Histopathology Report (if applicable in case/s) are submitted WITHOUT PATIENT IDENTIFIERS such as Name and Case number (anonymized data).	
Cases with Discussion	**Four of the 4 major cases above (2 Obstetrics and 2 Gynecology)**. TABULATION OF CASES/PROCEDURES with seven columns (in ARIAL font 12 pt, landscape view) • Tally number, Patient's age and OB score, Date admitted, Date discharged, Hospital where procedure was done • Admitting Diagnosis • Pre-operative Diagnosis • Management, Operation/Procedure done, Anesthesia done, Date done • Indication for Surgery/Procedure (INCLUDE Justification if there is deviation from standard of care) DO NOT leave this column blank. DO NOT copy pre-operative diagnosis. • Final Diagnosis • Outcome/Histopathology result	
	Supporting Documents – arranged following the sequence in "Tabulation of Cases/Procedures" *Refer to Appendix J.* A. Complete History 1) Chief Complaint	

	2) History of Present Illness 3) Past History 4) Family History 5) Personal and Social History 6) Menstrual History 7) Obstetrical History 8) Systems Review B. Physical Examination C. Laboratory Examinations/Ancillary Procedures D. Admitting Diagnosis E. Pre-operative Diagnosis F. Type of Operation; Operative Technique and Operative Findings G. Post-operative Diagnosis (include necessary post-operative discussion) H. Friedman's Curve or Partogram (for all dystocia and failed induction cases) I. Course in the Ward/Post-operative Management J. Final Diagnosis K. Discussion Proper: basis for diagnosis, differential diagnosis/diagnoses; justification for choice of diagnostic tests;justification for choice of management, pre-operative management; discussion of operative findings, outcome and postoperative management, and future plans for the patient. Discussion should be limited to ONE PAGE with a minimum of 500 words and a maximum of 600 words (written in ARIAL font 12 pt, single space, portrait view). It should be patient-focused/patient-centered with emphasis on the critical issues influencing the decision-making in the case. L. References/Bibliography – correct citation (superscripts in text), LATEST references and evidence from RECENT literature M. Operative Record – applicant types the EXACT contents of the Operative Record, but omits patient identifiers. (Typewritten in Arial font 12 pt, portrait view) The type of anesthesia used and duration of surgery must be stated. N. Operative Technique	

	O. Histopathology Report, if applicable - applicant types the EXACT contents of the histopathology report, with gross and microscopic descriptions but omits patient identifiers. (Typewritten in Arial font 12 pt, portrait view and stamped Certified True Copy by the Records Section or the Pathology department)	
All of the above requirements must be submitted book-bound with soft cover (total of two identical book-bound copies, one for the PBOG and one receiving copy of the applicant. Use A4-size paper with 2-inch margin on the left for the binding side.		