APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF (ACTIVE/VISITING)

Membership to the MEDICAL STAFF (Active/Visiting) of CAPITOL MEDICAL CENTER (CMC) is by application and, preferably, upon the invitation of members of the Active Medical Staff, through the recommendation of the Credentials Committee and with the final approval of the Board of Directors.

Minimum requirements for appointment to the CMC MEDICAL STAFF:

1. Graduate of an accredited medical school by the Professional Regulations Commission
2. Legally licensed to practice in the Philippines
3. Certified specialist and/or Fellow of Specialty societies and in active practice
4. Good moral character
5. For Active 1 and 2 applicants, ownership of prescribed number of shares of stocks

DOCUMENTARY REQUIREMENTS:

- Applicant must submit a properly filled-up Application Form for Appointment to the CMC Medical Staff. All information must be typed or legibly written.
- INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED
- Applicants for membership to the **VISITING staff must submit ALL documents** as listed below. Applicants for membership to the **ACTIVE staff to submit # 1-10 only**.
- **Kindly bring original documents for authentication purposes.**
- Documents to be submitted at the Medical Service Office together with the filled-up application form.

1. Letter of application/intent addressed to:
   JORGE T. LOGARTA, M.D., MMHoA, PSGS
   Medical Director
   Capitol Medical Center
2. Updated Curriculum Vitae
3. 3 Letters of Recommendation (at least), preferably from the following:
   a. Members of the active medical staff of CMC
   b. Chair or members of the department the applicant is presently connected
   c. Chairman or Training Officer of the Residency Training Program attended
   d. Practitioners from your professional discipline who have personal knowledge of your ability to practice
4. 2 pcs. each colored 2x2 & 1x1 recent ID picture (within 6 months of application)
5. Photocopy of Updated PRC ID
6. Photocopy of Updated PDEA S2 license for Anesthesiologist and Pain Specialist
7. Photocopy of Updated PHIC Accreditation ID
8. Photocopy of Updated Professional Tax Receipt (PTR)
9. Certificate of Good Standing from Specialty and/or Subspecialty Society
10. Photocopy of Updated Life Support Certification [Advance Cardiac Life Support (ACLS) or Basic Life Support (BLS) or Pediatric Advance Life Support (PALS)/ Neonatal Resuscitation Program (NRP)] whichever is applicable*
11. Photocopy of Medical School Diploma
12. Photocopy of PRC-PLE Board Certificate
13. Photocopy of Certificate of Specialty Training from an accredited residency program
14. Photocopy of Certificate of Fellowship/subspecialty Training (if applicable)

15. Photocopy of Specialty Board Certificates
16. Photocopy of BIR-TIN ID / Certificate of Registration 2303 – Certified True copy
17. Photocopy of Philippine Medical Association (PMA)/ Philippine Dental Association (PDA) Membership ID

*CMC POLICY ON BLS/ACLS REQUIREMENT

As part of the Department of Health (DOH) Level 3 Hospital Requirements, the following policy is being implemented by the CMC Medical Service Office:

1. ALL members of the CMC medical consultant staff must be BLS-certified.
2. Additionally, members of the Departments of Surgery, Orthopedics, OB-Gyn and Anesthesiology must be ACLS-certified.
3. The Department of Medicine shall determine who among the members of its consultant staff shall be required an ACLS-certification.
4. Consultants of the Department of Pediatrics are required to have Pediatric Advanced Life Support (PALS) and Neonatal Resuscitation Program (NRP) certification, as applicable.
5. BLS and ACLS courses may be organized by each department for its members or may be taken outside CMC provided they are accredited by the Philippine Heart Association, the American Heart Association, or the International Liaison Committee on Resuscitation (ILCOR).
6. Members of the consultant staff who are 60 years and above are not required to take the BLS and ACLS courses.
7. A copy of the updated BLS and ACLS certificates must be regularly submitted to the Medical Service Office.

CAPITOL MEDICAL CENTER, INC.
A MOUNT GRACE PARTNER

MEDICAL SERVICE

Applying for (Category) Check (✓) appropriate box	☐ VISITING ☐ Initial appointment ☐ Re-appointment
	☐ ACTIVE ☐ 1 ☐ 2 ☐ 3
	☐ Junior Consultant ☐ House Anesthesiologist

2x2 Photo

NAME: _____
Surname, First Name Middle Name

AGE: _____ GENDER: _____ CIVIL STATUS: _____ DATE OF BIRTH: _____

BIRTHPLACE: _____ CITIZENSHIP: _____

HOME ADDRESS: _____

TELEPHONE NO.: _____ CELLPHONE NO.: _____ E-MAIL ADDRESS: _____

TIN NO.: _____ GSIS/SSS NO.: _____ PHIC NO.: _____

NAME OF SPOUSE: _____ OCCUPATION: _____ CONTACT No.: _____

COLLEGE ATTENDED: _____ DEGREE: _____ YEAR GRADUATED: _____

MEDICAL SCHOOL ATTENDED: _____ YEAR GRADUATED: _____

INTERNSHIP (HOSPITAL): _____ YEAR GRADUATED: _____

RESIDENCY TRAINING

	DEPARTMENT/SPECIALTY	HOSPITAL	MONTH/YEAR
FIRST			
SECOND			
THIRD			
FOURTH			
FIFTH			

OTHER FORMAL TRAINING (Post-Residency, Fellowship, Post-Graduate Courses, Basic Science Courses, other Specialty Courses, etc.)

SPECIALTY/SUBSPECIALTY/FELLOWSHIP	INSTITUTION	MONTH/YEAR

PHILIPPINE MEDICAL BOARD EXAMINATION: _____

DATE: _____ PRC REG. NO.: _____

SPECIALTY EXAMINATION TAKEN: _____

BOARD: _____ DATE PASSED: _____

MEMBERSHIP TO SPECIALTY BOARD/SOCIETY: _____ YEAR CONFERRED: _____

SOCIETY: _____

CATEGORY: _____
(Regular / Associate / Fellow / Diplomate / Honorary)

PAST OR PRESENT ACADEMIC APPOINTMENTS:

1. _____
2. _____
3. _____

PRESENT MEMBERSHIP IN OTHER HOSPITALS:

1. _____
2. _____
3. _____

CLINIC ADDRESS AND SCHEDULE IN OTHER HOSPITALS/LOCATIONS:

1. _____
2. _____
3. _____

REFERENCES	ADDRESS	TEL NO/EMAIL ADDRESS
1. _____	___	_____
2. _____	___	_____
3. _____	___	_____

INTENDED SPECIALTY OF PRACTICE IN CAPITOL MEDICAL CENTER:

_____

By signing this application for the privilege to practice in Capitol Medical Center, I certify that all the information submitted by me in this application is true and complete to the best of my knowledge.

I also agree to:

1. Abide by the policies and regulations of the hospital and that of the CMC-Medical Staff, Inc., the medical staff organization of CMC.
2. Confine my practice to the medical field in which I am fully qualified as indicated above.
3. Follow the accepted principles of medical ethics.
4. Practice and contribute to the training programs and other activities of the hospital.

_____, M.D.
Signature over printed name

_____
Date

Action Taken: _____
Appointment recommended/ Deferred/ Not recommended

If not recommended/deferred, state reasons:

_____
_____
_____

Privilege limited to:

_____

CREDENTIALS COMMITTEE:

_____ _____
Section Head, Specialty/Subspecialty Training Officer of the Department

_____
Chairperson of the Department

RECOMMENDING APPROVAL:

_____ _____
Chairperson, Credentials Committee Assistant Medical Director for Professional Engagement

_____
Medical Director