

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. Original 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. Certified True Copy of Medical School Diploma
 12. Certified True Copy of PRC-PLE Board Certificate
 13. Certified True Copy of Certificate of Specialty Training from an accredited residency program
 14. Certified True Copy of Certificate of Fellowship/Subspecialty Training (if applicable)

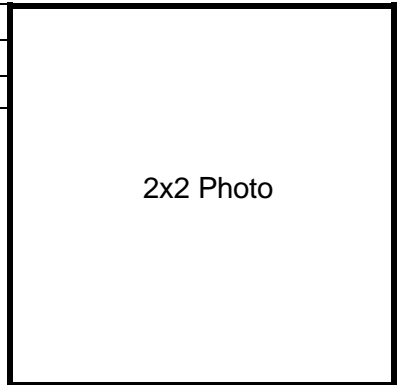
15. Certified True Copy of Specialty Board Certificates
16. Certified True Copy of BIR-TIN ID / Certificate of Registration 2303 – Certified True copy
17. Photocopy of Philippine Medical Association (PMA)/ Philippine Dental Association (PDA) Membership ID

***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.

Applying for (Category) Check (✓) appropriate box	<input type="checkbox"/> VISITING <input type="checkbox"/> Initial appointment <input type="checkbox"/> Re-appointment
	<input type="checkbox"/> ACTIVE <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
	<input type="checkbox"/> Junior Consultant <input type="checkbox"/> House Anesthesiologist



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