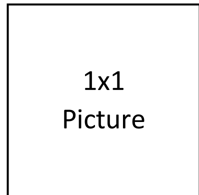
ST. CLARE'S MEDICAL CENTER, INC.
1838 Dian St., Palanan, Makati City
Telephone nos.8831-65-12 to 14

Approved Date: ____________________
Application No: ____________________



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Picture

Visiting Consultant's Application Form

Application Date: _______________

PERSONAL INFORMATION

Name: ______________________________ Nickname: ____________________

Contact Address: ______________________________ Telephone No.: ____________________

Name of other Clinics affiliated: ______________________________

Clinic's Contact Details: ____________________ Email Add: ____________________ Mobile No.: ____________________

Age: ________ Sex: ________ Marital Status: _____________ Date of Birth: ________________ Place of Birth: ____________________

PRC NUMBER: ____________________ PTR: ____________________ TIN: ____________________

PHILHEALTH ACCREDITATION NO.: ____________________ PHILHEALTH Validity: ____________________

EDUCATIONAL BACKGROUND

Pre-Medical Education

College: ____________________ Degree: ____________________ Date of Graduation: ____________________

Medical Education

Medical Institution: ____________________ Specialization: ____________________Date of Graduation: ____________________

Post Internship

Medical Institution: ____________________ Date of Completion: ____________________

Date of Physician's Board Examination:

Residency Training

Hospital	Specialty	(From-To) Date
____________________	____________________	____________________

Fellowship

Hospital	Specialty	(From-To) Date
____________________	____________________	____________________

DIMPLOMATE/FELLOWSHIP Specialty Board Passed: ____________________ _____Yes _____No Date: ____________________

How did you get to know of SCMC? ______________________________

If you were introduced by an existing Active or Visiting Consultant, a friend or colleague of St. Clare's Medical Center, please state the name and other details below.

Name: ____________________ Specialty: ____________________ Contact Details: ____________________

If you wish to refer someone to our institution, please state the name and other details below.

Name: ____________________ Specialty: ____________________ Contact Details: ____________________

Any marketing comments, suggestions & feedback:
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____
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I agree to abide the terms and condition of the Consultant's Program. I have enclosed the credentials needed for the processing of this application. I hereby certify that all information above are true and correct and that the documents submitted are updated and valid.

Date: ____________________

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SIGNATURE OVER PRINTED NAME