PHILIPPINE ACADEMY OF MEDICAL SPECIALISTS, INC

Penthouse B, 6th floor, DSL Bldg., 380 Del Monte Ave., San Francisco Del Monte, Quezon City
Tel. No. / Mobile Nos.: (02) 4145582 / 0922-8498552 / 0917-6256119 / 0999-8861402
Website: www.pamsinc.org E-mail: pamssecretariat@yahoo.com

APPLICATION FORM

2x2 photo

Family/ Surname	First Name	MI

Gender (M/F)	Civil Status	Citizenship

Religion	Birth Date (mm/dd/yy)	Birth Place

Home Address	
Office Address	
Telephone Numbers (please include area code)	Telefax No.
Email Address	Mobile number
Spouse Name	No. of Dependents

Medical Education

Name of College / University	Year Graduated
College/ University Address	

Internship

Hospital	Year
Address of Training Hospital	
Medical Board Licensure Examination License Number	Year

Post Graduate Training

Name of Institution	Year Attended
Residency	Fellowship
Teaching Position	Post Graduate Education

MEMBERSHIP/AFFILIATION IN OTHER HOSPITALS (PAST and PRESENT)		
Are you a member of PMA? __Y ___ N	Year	PMA No
Are you a member of other medical societies / association?		
Are you presently connected as faculty of any medical school? Y___ N__ If yes, Please indicate the following:		
Name of Institution		
Department	Position held	

Field of Specialty (sub specialties, if any)	
Are you certified by any specialty board? Y___ N ___	
If yes, Name the Specialty Boards	**Date Taken**

References:

Name	Address

In submitting this application to be a member of the PHILIPPINE ACADEMY OF MEDICAL SPECIALISTS, Inc., I agree to abide by the Constitution and By-Laws of the association and such rules and regulations have forth to be enacted

_______________________ APPLICANT'S SIGNATURE

_______________________ Date

MEMBERSHIP STATUS

I, the undersigned, hereby declare that all requirements submitted by the applicant to me are certified true and correct.

____

(Signature over Printed Name)

Sub Committee Chairman or Local Chapter President

RECOMMENDED ( ) NOT RECOMMENDED ( ) DEFFERED ( )

____

DATE

ACTION TAKEN BY THE BOARD OF TRUSTEES

MEMBERSHIP CONFIRMED ( ) OVER RULED ( ) DEFERRED ( )

RECOMMENDING APPROVAL BY: ____, M.D.

Chair Committee on Credentials

APPROVED BY : **LESMES C. LUMEN, M.D.**

Chairman Board of Trustees

____

DATE

Documentary Requirements:
The applicant shall submit the accomplished application form including three (3) sets of photocopies (with the original or certified true copies for presentation purposes) of the following to PAMS Board of Trustees:

1. **Diploma from the college or university**
2. **Photocopy of updated PRC**
3. **Certificate of Accredited Residency Training**
4. **PMA Cards**
5. **Certificate of Medical Specialist Qualifying Examination (DOH)**
6. **ID pictures (2 copies) 2x2**
7. **Membership fee payment**
8. **Recommendations of 2 Fellow PAMS Members or Chapter President**

For (CPM) Community and Preventive Medicine
5 years Government Service
- Service record from HRMO
- Cert. of DOH Training & Seminars
- Items No. 1, 2, 6, 7