Applicant Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_

Contact #: Landline \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRC # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Requirements**

1. **Scan copy of updated PRC ID**
2. **Scan copy of updated BLS/ACLS**
3. **Scan copy of certificate of employment or contract of employment from the hospital or free-standing hemodialysis unit**
4. **Strong and stable internet connection to maintain a stable video connection to run a webinar**

Practice:

* Internal Medicine
* Pediatrics
* Emergency Medicine
* Family Medicine
* General Medicine

Experience as a Physician-on-Duty in the Hemodialysis Unit/ Center

* 3 to <6 months
* 6 to <9 months
* 9 to <12 months
* >12 months

List of hemodialysis training within the last 5 years

|  |  |  |  |
| --- | --- | --- | --- |
| Course Title | Inclusive Date | Organized by: | Validity Period |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

List the hemodialysis unit/s, address and contact number of the institution where you work/ worked as a Physician-on-Duty

|  |  |  |  |
| --- | --- | --- | --- |
| Hemodialysis Unit | Address | Contact number/s | Months/Years worked |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Certified true by recommending nephrologist

|  |  |  |  |
| --- | --- | --- | --- |
|  | Name | Contact number/s | Verified by: |
| Hemodialysis unit/s |  |  |  |
| Medical Director/ Nephrologist/s |  |  |  |
| Human Resources Officer/s |  |  |  |

Approved by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature over printed name *Lpp/ipg/06-03–20*