THE PHILIPPINE ACADEMY OF OPHTHALMOLOGY, INC.

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For PAO use only:

Date Approved: ________

MEMBER-IN-TRAINING APPLICATION FORM

Please Type or Print Clearly

NAME:

____

LAST FIRST MIDDLE NAME

SEX: Male Female BIRTHDATE: ________________ BIRTHPLACE: ____________________

Month Day Year

NATIONALITY: ________________________

IF A FOREIGNER, PLS. INDICATE YOUR ACR NO.: ______________ EXPIRY DATE: ____________

PERMANENT ADDRESS: ____

____

MEDICAL SCHOOL: ______________________________________ YEAR GRADUATED: __________

ADDRESS OF MEDICAL SCHOOL: ____

RESIDENCY TRAINING INSTITUTION: ____

ADDRESS OF INSTITUTION: ____

YEAR LEVEL: ____________ YEAR OF COMPLETION: __________

PMA NO.: __________________ EXPIRY DATE: ______________

PMA LOCAL CHAPTER: ___________________________________

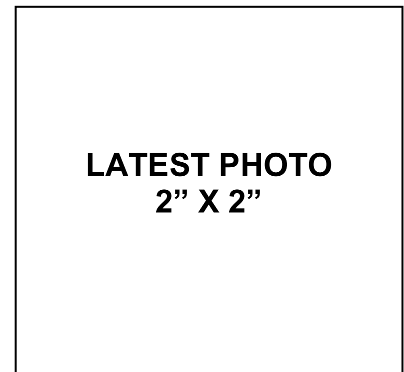
PRC NO.: _________________ EXPIRY DATE: ________________

COMPLETE HOME ADDRESS: ______________________________

____

E-MAIL _______________________________ TEL. _____________

MOBILE _________________________ FAX ________________



STATEMENT OF ENDORSEMENT

I hereby certify that the applicant is presently under the Ophthalmology training program of the Institution stated above. I further certify that the said training program is duly accredited by the Philippine Board of Ophthalmology.

____

Name of Department Chairperson Signature Date

MITFORM_ as of JUNE 21, 2016

By signing and submitting this application, I certify that all information submitted on or in support of this application is true, accurate, and complete, and I understand and agree that all such information is subject to review and verification by or under the supervision of the Executive Council of the Philippine Academy of Ophthalmology, Inc. I authorize and consent to that review and verification. I authorize and consent to all inquiries and good faith disclosures concerning me that may be made in the course of that verification process. I understand that I may become a ***Fellow or Member*** of the PAO only upon the affirmative vote of the Executive Council. I agree to comply with the ***PMA Code of Ethics*** as a condition of initial and continued membership in the PAO. I understand and agree that If I am elected Member of the PAO, my continued status as a Member will be subject to all of the terms and conditions of the Bylaws of the PAO, and that the Executive Council may revoke my membership if this application contains or is supported by information that omits or contains a substantial misstatement of any fact required or permitted by this application or the related instructions to be included on or submitted with or in support of this application.

N.B. For foreign nationals, Please submit the following:

1. Photocopy of the 1st page of your recent passport

2. Photocopy of diploma from medical institution you graduated from

SIGNATURE OF APPLICANT: ____

DATE OF APPLICATION: ____

METHOD OF PAYMENT:

- ☐ **CASH**
- ☐ **CHECK**
  - **CHECK NO.:** ____________ **DATE:** ____________
- ☐ **CREDIT CARD**
  - **CARD NO.:** ____________ **CARDHOLDER'S NAME:** ____________
  - **EXPIRY DATE:** ____________

RECEIVED BY: ____________________________

DATE: ____________________________

OR NO.: ____________________________