



# THE PHILIPPINE ACADEMY OF OPHTHALMOLOGY, INC.

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Amorsolo cor dela Rosa Streets,  
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Fax No.: (+632) 813-5331  
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Website: [www.pao.org.ph](http://www.pao.org.ph)

*For PAO use only:*  
**Date Approved:** \_\_\_\_\_

## MEMBERSHIP APPLICATION FORM

Type of Membership applied for:  ASSOCIATE (Non Diplomate)  MEMBER (Diplomate)

*Please Type or Print Clearly*

### **PERSONAL INFORMATION:**

NAME: \_\_\_\_\_  
LAST FIRST MIDDLE NAME

SEX:  MALE  FEMALE BIRTHDATE: \_\_\_\_\_ BIRTHPLACE: \_\_\_\_\_  
MONTH DAY YEAR MARITAL STATUS: \_\_\_\_\_

MEDICAL SCHOOL: \_\_\_\_\_ YEAR GRADUATED: \_\_\_\_\_

RESIDENCY (INSTITUTION): \_\_\_\_\_ YEAR GRADUATED: \_\_\_\_\_

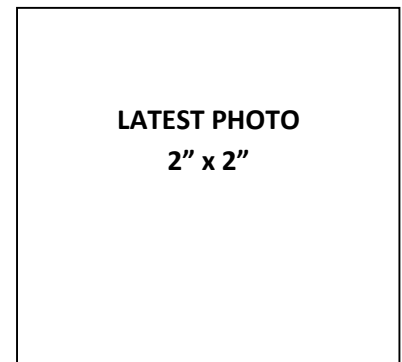
### **PBO CERTIFICATION:**

WRITTEN EXAMINATION ( YEAR TAKEN: \_\_\_\_\_ )

ORAL EXAMINATION ( YEAR TAKEN: \_\_\_\_\_ )

PASSED

NOT PASSED



PRC NO.: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

PHILHEALTH NO. \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

PMA NO.: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

PMA COMPONENT SOCIETY: \_\_\_\_\_

RESIDENCE ADDRESS: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ TEL. NO.: \_\_\_\_\_

MOBILE NO.: \_\_\_\_\_ FAX NO.: \_\_\_\_\_

MAILING ADDRESS (IF DIFFERENT FROM RESIDENCE): \_\_\_\_\_

### **CLINIC / PRACTICE INFORMATION:**

PRIMARY (MAIN) CLINIC ADDRESS: \_\_\_\_\_

SCHEDULE: \_\_\_\_\_ TEL. NO.: \_\_\_\_\_

SECONDARY CLINIC ADDRESS: \_\_\_\_\_

SCHEDULE: \_\_\_\_\_ TEL. NO.: \_\_\_\_\_

HOSPITAL AFFILIATION/S: *Please Print Name of Hospital, Address and Contact numbers*

PRIVATE: \_\_\_\_\_

GOVERNMENT: \_\_\_\_\_

PAO AFFILIATE CHAPTER / SUBSPECIALTY SOCIETY: \_\_\_\_\_

### **SUBSPECIALTY:**

- |  |  |
|--|--|
| <input type="checkbox"/> GENERAL OPHTHALMOLOGY     | <input type="checkbox"/> OCULOPLASTY         |
| <input type="checkbox"/> E.E.N.T                   | <input type="checkbox"/> GLAUCOMA            |
| <input type="checkbox"/> RETINA & VITREOUS         | <input type="checkbox"/> UVEITIS             |
| <input type="checkbox"/> EXTERNAL DISEASE          | <input type="checkbox"/> ORBIT               |
| <input type="checkbox"/> PEDIATRIC OPHTHALMOLOGY   | <input type="checkbox"/> OCULAR PATHOLOGY    |
| <input type="checkbox"/> NEURO-OPHTHALMOLOGY       | <input type="checkbox"/> OPTICS & REFRACTION |
| <input type="checkbox"/> CORNEA / EXTERNAL DISEASE | <input type="checkbox"/> LOW VISION          |

**NOTE:** ALL APPLICANTS MUST HAVE COMPLETE REQUIREMENTS BEFORE SUBMISSION; INCOMPLETE REQUIREMENTS WILL NOT BE CONSIDERED AS AN

<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	1. Have you ever been denied membership to any hospital staff, professional society, or government agency accreditation (Philhealth, etc)? If yes, explain: _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	2. Have you ever been sanctioned or dismissed by any hospital or department committee, any professional society, or government agency related to medical practice? If yes, explain: _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	3. Have you ever been convicted or do you have any case pending criminal in court pertaining to criminal behavior or related matters? If yes, explain: _____

**STATEMENTS OF ENDORSEMENT**

I hereby certify that the applicant has successfully completed an Ophthalmology training program in the institution stated in the reverse side hereof.

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NAME OF DEPARTMENT CHAIRPERSON (SIGNATURE OVER PRINTED NAME)	DATE
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**I hereby certify that the applicant has successfully passed the written and oral examinations given by the Philippine Board of Ophthalmology**

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CHAIR, PHILIPPINE BOARD OF OPHTHALMOLOGY (SIGNATURE OVER PRINTED NAME)	DATE
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I hereby certify that i am a Member/Fellow of the Philippine Academy of Ophthalmology and have personal knowledge of the applicant and am familiar with the applicant's professional competence and conduct; that the applicant has attained a high level of professional competence and conforms to the ethical standards embodied in the PMA and PAO Code of Ethics; and that upon request I shall provide all necessary information to verify the truth and accuracy of this certification.

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\_\_\_\_\_  
SIGNATURE OF FELLOW/MEMBER

\_\_\_\_\_  
SIGNATURE OF FELLOW/MEMBER

\_\_\_\_\_  
SIGNATURE OF FELLOW/MEMBER

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PRINTED NAME OF FELLOW/MEMBER

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PRINTED NAME OF FELLOW/MEMBER

\_\_\_\_\_  
PRINTED NAME OF FELLOW/MEMBER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

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 contain 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.

**SIGNATURE OF APPLICANT:** \_\_\_\_\_

**DATE OF APPLICATION:** \_\_\_\_\_

<b>METHOD OF PAYMENT:</b>		<b>RECEIVED BY:</b> _____
<input type="checkbox"/> CASH		
<input type="checkbox"/> CHECK	• CHECK NO.: _____ DATE: _____	<b>DATE:</b> _____
<input type="checkbox"/> CREDIT CARD	• CARD NO.: _____ CARDHOLDER'S NAME: _____	<b>OR NO.:</b> _____
	• EXPIRY DATE: _____	