THE PHILIPPINE ACADEMY OF OPHTHALMOLOGY, INC.

Unit 815, Medical Plaza Makati Cond.,
Amoroslo cor dela Rosa Streets,
Legaspi Village, Makati City 1223, Philippines
Tel. Nos.: (+632) 813-5324; 813-5318
Fax No.: (+632) 813-5331
Email: secretariat_pao@globelines.com.ph
Website: www.pao.org.ph

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**

LATEST PHOTO
2" x 2"

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:

- ☐ **GENERAL OPHTHALMOLOGY**
- ☐ **E.E.N.T**
- ☐ **RETINA & VITREOUS**
- ☐ **EXTERNAL DISEASE**
- ☐ **PEDIATRIC OPHTHALMOLOGY**
- ☐ **NEURO-OPHTHALMOLOGY**
- ☐ **CORNEA / EXTERNAL DISEASE**
- ☐ **OCULOPLASTY**
- ☐ **GLAUCOMA**
- ☐ **UVEITIS**
- ☐ **ORBIT**
- ☐ **OCULAR PATHOLOGY**
- ☐ **OPTICS & REFRACTION**
- ☐ **LOW VISION**

☐ YES ☐ NO 1. Have you ever been denied membership to any hospital staff, professional society, or government agency accreditation (Philhealth, etc)?
If yes, explain: _____

☐ YES ☐ 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: _____

☐ YES ☐ 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.

_____

NAME OF DEPARTMENT CHAIRPERSON (SIGNATURE OVER PRINTED NAME) **DATE**

I hereby certify that the applicant has successfully passed the written and oral examinations given by the Philippine Board of Ophthalmology

_____

CHAIR, PHILIPPINE BOARD OF OPHTHALMOLOGY (SIGNATURE OVER PRINTED NAME) **DATE**

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

_____
SIGNATURE OF FELLOW/MEMBER

_____
PRINTED NAME OF FELLOW/MEMBER

_____
DATE

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_____
SIGNATURE OF FELLOW/MEMBER

_____
PRINTED NAME OF FELLOW/MEMBER

_____
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

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.: __ _____