



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

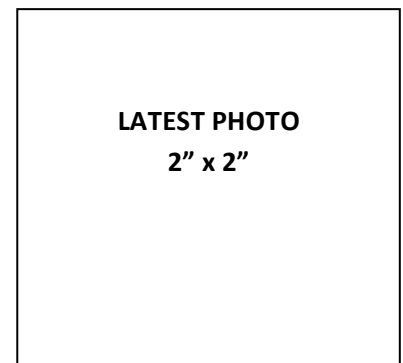
SEX: MALE FEMALE BIRTHDATE: _____ BIRTHPLACE: _____
MONTH DAY YEAR MARITAL STATUS: _____

MEDICAL SCHOOL: _____ YEAR GRADUATED: _____

RESIDENCY (INSTITUTION): _____ YEAR GRADUATED: _____

PBO CERTIFICATION:

- WRITTEN EXAMINATION (YEAR TAKEN: _____)
 ORAL EXAMINATION (YEAR TAKEN: _____)
 PASSED NOT PASSED



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 |

<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.

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

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SIGNATURE OF FELLOW/MEMBER

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SIGNATURE OF FELLOW/MEMBER

PRINTED NAME OF FELLOW/MEMBER

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

SIGNATURE OF APPLICANT: _____

DATE OF APPLICATION: _____

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