

**PERSONAL INFORMATION SHEET FOR MEDICAL EXAMINER**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: (last name, first name, middle name) | | | |  | Age | | Gender |
|  | |  |  |  |  |  |  |
| Birthday (mm/dd/yyyy) | |  |  |  | Birthplace | | Citizenship |
|  | |  |  |  |  |  |  |
| Civil status | |  |  |  | Tel. no | | Mobile no |
|  | |  |  |  |  |  |  |
| Residential address | |  |  |  |  |  |  |
|  | |  |  |  |  |  |  |
| Clinic address | |  |  |  |  |  |  |
|  | |  |  |  |  |  |  |
| E-mail address | |  |  |  |  |  |  |
|  | | |  | | |  |  |
| Peso savings account name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |  |
| Branch of account\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |  |  |
| Peso savings account number | | | | |  |  |  |
|  | **BPI (preferred**) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |
|  | Metrobank | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |
|  | Security Bank | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |
| Others: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |  |
| Tax Identification Number | | | | |  |  |  |
|  | | |  |  | |  |  |
| **EDUCATIONAL BACKGROUND and MEDICAL TRAINING** | | | | | | |  |
|  | | |  | |  |  |  |
| Name of medical institute: | | | | |  |  | Year graduated: |
| Physician licensure no: | |  |  |  |  |  | Year exam taken: |
| Field of residency training : | | | | |  |  | Year graduated: |
| Name of hospital and address: | | | | |  |  |  |
| Field of fellowship training: | | | | |  |  | Year graduated: |
| Name of hospital and address: | | | | |  |  |  |
| **EMPLOYMENT RECORD (for the last five years only)** | | | | |  |  |  |
|  |  |  |  | |  |  |  |
|  | **Period** |  | **Position** | |  |  | **Employer** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

**Are you currently or have you ever been an examiner for a life insurance company? \_\_\_\_\_**

**If so, name the companies and state the period of appointment:**

|  |  |
| --- | --- |
| **Life insurance company** | **Period** |
|  |  |
|  |  |
|  |  |

**Are you equipped with the following medical equipment? Please check as applicable:**

\_\_\_\_\_\_\_\_\_\_\_ Sphygmomanometer \_\_\_\_\_\_\_\_Portable weighing scale

\_\_\_\_\_\_\_\_\_\_\_ Tape measure \_\_\_\_\_\_\_\_ Chemical urinalysis set

\_\_\_\_\_\_\_\_\_\_\_ Portable Electrocardiogram

What clinic or laboratory/ies are you affiliated with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you willing to examine clients at their place of business or residence? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to Pru Life UK? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**References (provide at least two):**

|  |  |  |
| --- | --- | --- |
| **Name** | **Position** | **Address and telephone no.** |
|  |  |  |
|  |  |  |

**By accomplishing this form, I hereby:**

1. **attest to the truth and completeness of the foregoing information supplied; and**
2. **agree to and authorize the lawful use, processing and storage by Pru Life UK of the forgoing information supplied and waive my right under Republic Act No. 10173 (the Data Privacy Act of 2012) and any such applicable data protection legislation which may be in force in the future in relation thereto. Signed this \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.D.**

**Signature over printed name**

**Submitted to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***(Please attach a copy of your valid PRC license and one government -issued ID)***

***Revised PIS form 2015***