Appendix A

PLEASE ATTACH YOUR RECENT PHOTOGRAPH

APPLICATION FOR OBSERVER SHIP/CLINICAL ATTACHMENT

PERSONAL DATA

1. Name: _____
   Last *Middle* *First*

2. Date of Birth:_____ 3. Sex: Male Female
   Year *Month* *Day* *Age* *(Circle One)*

4. Marital Status:

5. Nationality: _____ 6. Passport Number _____

7. Issued at: _____ 8. Issuance Date: _____

9. a) Permanent Address: _____
   (Street Address)

   _____
   (P.O.Box)

   _____
   (City, Province, County, Postal Code)

   b) Home Phone No: _____ c) Business Phone No: _____

   d) Fax No: _____ e) E-Mail Address:_____

10. Emergency Contact Name: _____
    Last *Middle* *First* *Relationship*

    a) Address: _____
    (Street Address)

    _____
    (City, Province, Country, Postal Code)

    b) Home Phone No: _____ c) Business Phone No:_____

    d) Fax No:_____ e) E-Mail Address:_____

PROFESSIONAL TRAINING /EXPERIENCE DATA

A. GRADUATE

COLLEGE_____

UNIVERSITY _____

YEAR OF GRADUATION_____

INTERNSHIP INSTITUTION _____

ADDRESS _____

B. POST GRADUATE

COLLEGE_____

UNIVERSITY_____

YEAR OF GRADUATION _____

SPECIALITY_____

C. SUPER SPECIALIZATION INSTITUTION _____

YEAR OF COMPLETION _____

FIELD OF SUPER SPECIALIZATION_____

MCI REG. NO. _____ **State Medical Council REG. NO.** _____

PROFESSIONAL PRACTICE DATA
PREVIOUS EMPLOYMENT (EXCLUDING INTERNSHIP & POST GRADUATE TRAINING)
In chronological order, please list places of employment starting with the most recent to the first:

HOSPITAL / INSTITUTE & DESIGNATION	FROM TO	DEPARTMENT	REASON FOR LEAVING

ANY ADDITIONAL INFORMATION

_____

_____

_____

Identify the clinical areas or programs in which you are most interested: (prioritized):

_____

_____

_____

_____

List at least THREE objectives you hope to accomplish during your training at Max Healthcare (prioritized):

_____

_____

_____

_____

List any other specific requests you may have during your stay at Max Healthcare:

_____

_____

_____

_____

HEALTH STATUS

1. Are you able to perform the mental and physical tasks necessary to render your professional services and to exercise the clinical privileges requested safely and competently?

   Yes ☐ No ☐

2. Are you currently taking any medication that affects either your clinical judgement or motor skills?

   Yes ☐ No ☐

3. Most recent physical examination: Date _____ Performed By_____

   (mo / year) (physician name)

By signing this application, I certify that the current status of my physical and mental health are commensurate with the ability necessary to fulfil my Clinical Membership responsibilities and to carry out the patient care activities related to the clinical privileges requested. I agree that if my physical and /or mental health should be questioned, in good faith, by the Medical Director and /or Credentialing Committee, I will submit myself to an adequate examination by a qualified examiner who has been mutually agreed upon by myself and the above persons or committee who have requested the examination.

_____ _____

Signature Date

REFERENCES

Please list the names and addresses of three references (2 clinical) who have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others. The named references must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time. None of the individuals should be related to you by family, or by current or impending professional partnership / financial association.

1. Name _____ (CLINICAL) Designation _____

   Institution Address & Phone No. _____

2 . Name _____(CLINICAL) Designation _____

   Institution Address & Phone No._____

_____ _____

Signature Today's Date